# AMERICA'S NEED FOR HEALTH REFORM

## HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

## COMMITTEE ON ENERGY AND COMMERCE

## HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

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# CONTENTS

# AMERICA'S NEED FOR HEALTH REFORM

**THURSDAY, SEPTEMBER 18, 2008**

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
*Washington, DC.*

The subcommittee met, pursuant to call, at 9:45 a.m., in room 2123 of the Rayburn House Office Building, Hon. Frank Pallone, Jr. (chairman) presiding.

Members present: Representatives Pallone, Towns, Green, DeGette, Capps, Baldwin, Schakowsky, Solis, Hooley, Matheson, Dingell (ex officio), Deal, Shadegg, Murphy, and Burgess.

Staff present: Bridgett Taylor, Purvee Kempf, Tim Gronniger, Hasan Sarsour, Jodi Seth, Brin Frazier, Lauren Bloomberg, Bobby Clark, Ryan Long, Clay Alspach, Brandon Clark, and Chad Grant.

**OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY**

Mr. PALLONE. The meeting of the subcommittee is called to order, and today we are having a hearing on "America's Need for Health Reform." I recognize myself initially for an opening statement.

When it comes to our Nation's healthcare system, I think there is at least one thing that we can all agree on, that our healthcare system is in crisis and is getting worse every day. The trends we are seeing today are truly frightening. Healthcare costs are climbing, access is eroding, and the quality of care is unpredictable. The United States spends approximately $2.1 trillion on healthcare annually, approximately 16 percent of our entire economy, and this is about twice what we spent 10 years ago. We outspend any other country when it comes to healthcare, but what has all this money brought us?

More and more Americans join the ranks of the uninsured every day. Today there are roughly 45 million Americans who do not have health insurance, and as I said, approximately 16 percent of the U.S. population. This is a problem that is only going to get worse. As the economy continues to weaken, more and more working Americans and their families are falling into the same trap. Nearly half the increase in the uninsured population between 2005 and 2006 occurred among middle-income families.

Part of the problem has been that healthcare costs continue to skyrocket at alarming rates. The average cost of a family employer-based insurance policy in 2007 was $12,106, or nearly the full-year,

full-time earning of a minimum wage job. The cost of a similar policy in the individual market would be prohibitively more expensive, out of reach for far too many working American families. And contrary to some opinions, the problems that people face when it comes to healthcare are not their own. It is nice to talk about taking ownership over your healthcare and having some skin in the game, but the truth of the matter is, we are all in this together. Rising costs and increasing numbers of uninsured Americans seriously impact our economy and society as well as further distress our weakening healthcare system.

As healthcare costs increase, it strains businesses and employers and puts them at a competitive disadvantage globally. Employer-sponsored health insurance premiums rose by almost 100 percent between 2000 and 2007, making it increasingly difficult for employers to continue to offer health insurance to their workers. Instead, more and more businesses are shifting the costs of health insurance to their employees at a time when healthcare costs are rising substantially faster than wage growth.

The impact of the uninsured on our communities is tremendous. We have 45 million Americans who cannot call a doctor to get an appointment, who do not have access to preventative care and who are forced to use the local emergency room as their primary source of care. Not only are these people sicker because they put off getting treatment and therefore more expensive to treat but they also are seeking care in a setting that costs our healthcare system more money.

Hospitals in my home State of New Jersey are grappling with providing rising amounts of charity care that increases their bad debt. Many hospitals cannot afford this growing financial burden and the State of New Jersey is having increasing difficulty in reimbursing hospitals for the charity care they provide. I will note that my governor, Jon Corzine, is with us today and can talk about many of the challenges our State faces because of our crumbling healthcare system. Governor Corzine will also be able to talk about what States are doing to answer the call to reform our Nation's healthcare system. New Jersey, Massachusetts, New York, and many other States are experimenting with new and innovative ways to expand their health insurance for their residents but they can't do it alone. The Federal Government will need to take a leading role in reforming our healthcare system.

All of these problems are interconnected, whether it is cost, access or quality. We need a healthcare reform plan that looks at the inadequacies of our healthcare system in its entirety and begins to address its failings. Fortunately, many people are talking about healthcare reform right now. Healthcare has become a critical part of the national debate, which reflects the growing anxiety many Americans share about the current state of our healthcare system.

In the end, we need to recognize that when it comes to healthcare, having it shouldn't be a luxury reserved just for those lucky enough to afford it. It is a basic human right, and we as a country, as a society have to ask ourselves, is it OK for Members of Congress to have the best healthcare in America but not 45 million other Americans? Is it OK to let our families, friends and neighbors continue to fall through the cracks of our broken

healthcare system or are we going to finally resolve ourselves to providing affordable, accessible, and high-quality healthcare to every American citizen, and I think the answer is clear.

I want to thank our witnesses. We have a great panel today, a pretty large panel, but I do appreciate your all being here. We are eager to hear your testimony.

Mr. PALLONE. I now recognize our ranking member for today, Mr. Murphy.

**OPENING STATEMENT OF HON. TIM MURPHY, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA**

Mr. MURPHY. Thank you, Mr. Chairman. Thank you so much for holding this important hearing on healthcare reform, and I also would like to welcome the distinguished panel of folks, experts from around the country who are here to give us their input.

As we are talking about healthcare reform, you alluded to a number of things, Mr. Chairman, and I appreciate that in terms of the uninsured and their access to care. I want to make sure, however, when we talk about healthcare reform, the emphasis is on reform, because healthcare reform is not just about who is paying but what we are paying for, and so often when we look at healthcare issues, we talk about such things as saying healthcare is expensive, let us have the government take it over, or healthcare is expensive, let us offer tax credits for people. In either case, the government is footing a lot of the bill but I am not sure it gets down to the fundamentals of our forum, and I think as we look at this, as you have heard me say many times on this committee, there are a couple of things where I think we can save massive amounts of money but we have to make sure we are tackling these.

One, of course, is an area I frequently talk about, and that is the area of hospital-acquired infections. If you have $50 billion a year wasted on preventable infections, that is money we could be saving the healthcare system. As of today, 62,000 people have died in this country just since January 1 from healthcare-acquired infections out of 1.1 million cases and that amounts to $31,000,500,000 wasted this year on preventable infections.

But there is another area too when it comes to providing healthcare for the uninsured, and that is an issue that this committee tackled before in Mr. Green's bill regarding community health centers. An amendment we put into that bill would have allowed physicians to volunteer at community health centers. This is intuitively obvious. After all, if you have community health centers, the 6,000 physicians that provide care at these centers around the country, there are not enough to help the 1,100 community health centers and the 16 million people who use these things. Wouldn't it be nice if we allowed physicians to volunteer, and indeed, in Mr. Green's bill, we allowed that, saying they would be covered under the Federal Torts Claim Act. The Senate, we understand, pulled that part of the bill and it is important that the House works very hard to get that reinstated. When we find that community health centers save about 30 percent in annual spending on Medicaid patients due to reduced special care referrals and fewer hospital admissions, that is a massive savings. As a matter of fact, the CBO

also said that if we allowed physicians to volunteer, then the impact on the federal budget would be zero. We don't have a lot of situations like that, but to be able to provide healthcare for folks with physicians who want to be Good Samaritans and give some of their care, you would think that would be a healthcare reform that we understand that we really could afford.

A couple years ago we found out that the actual numbers of physicians where there is need for primary care, nurse practitioners, physician assistants, midwives, dentists, et cetera, the vacancies were huge, also with OB/GYNs, family physicians, pediatricians, and the vacancy rates are particularly high among rural and inner city health centers, which range from 19 percent to 29 percent of their workforce. What I think is so hugely important that as the conference committees are meeting on the bill involving community health centers, is that the House continue to push very hard for some of these real reforms. We can make sure that while the Federal Government is looking at a $200 billion combined bailout of Fannie Mae and Freddie Mac and $85 billion for AIG and other billions sent out to J.P. Morgan, Chase and Bear Sterns, and all those other things, we surely can find a way to work zero in the equation and allow physicians to volunteer. It is just wrong, it is unconscionable. And I hope as we discuss the issues of healthcare reform, we look at these things too, and Mr. Chairman, I am going to give you a copy of something that I wrote a while ago. It is called "Critical Condition: The State of the Union's Healthcare," and it is light reading. It is only about 60 pages long. But you know me, I obsess on details. But this also outlines a lot of the things that I think we could be doing to reduce healthcare costs and I hope we can include this in part of our conversation in the future.

With that, I thank you so much for doing this hearing and I look forward to continuing to work with you.

Mr. PALLONE. Thank you so much, and let me say, it is not that often that a member actually gives me a document so important that they wrote themselves. That is great. Thank you.

Next for an opening statement, the chairman of our full committee, who has been working on healthcare reform for so many years so successfully, Mr. Dingell.

**OPENING STATEMENT OF HON. JOHN D. DINGELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN**

Mr. DINGELL. Mr. Chairman, thank you, and I commend you for this hearing today, and I welcome a very distinguished panel of witnesses for their joining us. I thank them for their kindness to us, and I know that they will make this a valuable hearing in our effort to see to it we address the problems of healthcare to our people.

I want to express my particular pleasure at seeing Elizabeth Edwards here. She is a great friend of the lovely Debra and I and I want her to feel welcome today. We are honored you are with us. And I particularly want to welcome Governor Jon Corzine. Governor, welcome. We had the privilege of working with you when you were in the Senate. It was always a great pleasure, and your leadership in healthcare and other important matters is very much

appreciated. Thank you again to our other panelists. Thank you also.

This is an important hearing, and it is necessary not only to review the status of our healthcare system but also to begin to prepare for what we are going to do to see to it that we finally make it something which works in the interest of all of our people. Today we are going to work particularly on the role of employer-sponsored coverage, the individual insurance market, the role of public programs such as Medicare, Medicaid, and the State Children's Health Insurance Program, States' perspective on healthcare coverage, and the growing number of uninsured Americans. Perhaps most importantly, we will lay the foundation for future discussions on healthcare reform, something desperately needed. Next year will bring us, we hope, great opportunities to repair and to strengthen our healthcare system and our witnesses today I again thank because they are going to provide valuable insights to help us as we focus our efforts ahead to 2009.

It is a curious anomaly we confront in this country. Our healthcare system is the best in the world. It is regrettably also the worst because we have 47 million Americans who have no access. People live in terror of loss of their policies of health insurance, and worse, large numbers of people are either uninsured, underinsured, or suffer from severe problems in terms of being able to achieve healthcare in a fashion that is needed. We rank with the Third World with regard to infant mortality and we have the unfortunate fact that many of our people are dying before they should and that our life expectancy does not match that of other developed nations. Forty-seven million Americans, until recently, were without health coverage. We have changed that a little bit better by seeing to it that we have increased the number of people who are under government-sponsored programs, but 9 million of our people who are not covered are children, and they could have had coverage had it not been for a veto of the President of the SCHIP program, which was a valuable, useful, and forward-looking step that this committee took to see to it that we addressed the needs of one of our most vulnerable groups in this society.

The last time we launched a serious health reform program, our healthcare spending was 14 percent of GDP. Today it is 17 percent. And we find that General Motors spends more on healthcare than it does on steel and we find also that Starbucks spends more on healthcare than it does on coffee—an entirely unacceptable consequence. Our healthcare system is not just morally indefensible, it is economically untenable. It is destroying the largest corporations and small businesses alike, and our companies simply cannot compete with their foreign competition because of the excessive costs of healthcare that they bear and the consequences of that are of course that every person who receives healthcare in this country is endangered.

I am pleased to note that it is 60 years since President Truman issued the first call for a national healthcare plan. Regrettably, the Nation has not heard it and opposition from special interests has prevented that from coming to be. In 1942, my father, John Dingell, Sr., tried to answer that call by introducing the first national health insurance act, and I have carried on my dear old dad's work

opening each session by introducing a bill to provide Americans with adequate health coverage.

We think that we are going to move forward next year, and I certainly hope that the issues of adequate healthcare for our people will be addressed as the campaign goes forward because the American people want something done about this problem and your leadership, Mr. Chairman, on this matter holding this hearing and the assistance of our very, very valuable panel is going, I hope, to help prepare us for this to give us an understanding of what needs to be done and to establish a clear recognition of a great public need unanswered.

Thank you, Mr. Chairman.

Mr. PALLONE. Thank you, Chairman Dingell.

I next recognize our ranking member, Mr. Deal from Georgia.

Mr. DEAL. Thank you, Mr. Chairman, and we have a very distinguished panel here today who represent a very wide spectrum of positions and opinions on the delivery of healthcare and the future of healthcare in this country, and in deference to the time that will be required to hear your testimony, I am going to reserve any other time and not use it at this point and just simply welcome all of you here today. We are pleased to have all of you. Thank you.

Mr. PALLONE. Thank you.

Next is our newly victorious member from New York, Mr. Towns.

**OPENING STATEMENT OF HON. EDOLPHUS TOWNS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK**

Mr. TOWNS. Thank you very much, Mr. Chairman. Let me thank you for holding this hearing. Let me begin by welcoming the very distinguished panel members. It is good to see all of you and really appreciate you coming to share with us because this is a very serious situation that we really must deal with. I welcome the opportunity to explore the reasons why a nationalized approach to reforming healthcare is needed.

Mr. Chairman, I am a firm believer that we in this country need universal healthcare now. Last year, I recall giving a speech on the House floor in support of House efforts to expand SCHIP. As I was bearing witness, in comes a staffer to inform me to stop my speech because the Administration just vetoed the SCHIP bill and what I was saying was no longer relevant. It is still beyond me how anyone could deny coverage to our Nation's most needy. When we passed the SCHIP expansion legislation, there were 2.6 million uninsured New Yorkers, 400,000 of whom were children. Now that we are experiencing a difficult economic downturn, we know more people regretfully will be out of work and in dire need of healthcare.

I am anxious to examine the role of employer-sponsored coverage, the individual insurance market, the role of public programs such as Medicare, Medicaid, and the State Children's Health Program, States' perspectives of healthcare coverage, the uninsured, the underinsured. Given that our healthcare system is obviously broken, we have the chance to fix it. I intend to be on the side of the angels in that effort.

With that, I appreciate the witnesses today in shedding light on the problem, but let me say that, let us take the word "reform"

very seriously. Around here I found over the years that reform does not mean what really reform should mean. Reform around here means cut the budget. I think that we should look very seriously at ways and methods that we can improve our healthcare system and that we should reform it in a very positive way, not just loosely use the word "reform."

Thank you very much for the opportunity. I yield back.

Mr. PALLONE. Thank you, Mr. Towns.

The gentleman from Texas, Mr. Burgess, is recognized for an opening statement.

**OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS**

Mr. BURGESS. Thank you, Mr. Chairman, and thank you for convening this hearing. It is an important topic. We have certainly have a significant panel of witnesses here today, experts to challenge some of our thinking and preconceived notions, and I appreciate the opportunity as always on this committee to participate in this type of discussion.

Certainly in this country we are at a crossroads when it comes to healthcare. For somebody who has spent a lifetime in healthcare, I will just tell you, it is significant for me that both of the major parties' nominees for President are talking about healthcare. It is probably one, two, or three on each of their lists, depending what else is in the headlines that day, and I think that is a good thing. We basically have two directions in which we might go because there are significant differences envisioned from both of the candidates, and as a consequence, we will have a referendum in November, and as a consequence of the referendum, we will have a mandate as we start into next year, and we will make that decision. Do we believe that the individual should retain some ability to determine what is involved in their healthcare or do we yield to the supremacy of the State, and it will be an interesting outcome this November.

Now, what about models for reform? We are going to hear something about that this morning. Oftentimes I am asked, what is the biggest single-payer healthcare system in the world? I think it is us. I think with our Medicare, Medicaid, VA system, federal prison system, all of the parts that are paid for by the Federal Government, I think it is us. Is this a model for reform? Well, certainly the world in which I live right now, I spend the bulk of my time dealing with problems that are caused for people from our Medicare, Medicaid, and VA system, whether it is the patient who can't get what they need or the provider who feels that their services have once again been devalued, so it is a major consumer of my time.

Now, Alan Greenspan, talking to a group of us right before he left Capitol Hill said someone asked him if we could continue to pay for Medicare in the future. He thought for a minute and said I think we will be able to because Congress will make the right decisions. That actually was a little chilling itself. But then he stopped and said, what concerns me more is, will there be anyone there to deliver the services when you require them? And that is something that I think this committee needs to really focus on. We

passed a very small bill yesterday in some of our public health bills to deal with physician workforce issues at the residency level. We have other opportunities. We haven't really faced the biggest problem of all, which is a sustainable growth rate formula. Sure, we delayed it once again in July but we have a huge cliff we are going to fall off in a little over a year's time and no one right now is talking about what we do to prevent that train wreck when it happens and we are not really addressing any visionary changes in the health proficient scholarship loan program. It has been a long time but really does need to be transformed for the 21st century.

So I think even Dr. Zerhouni, who came and talked to us last week or 2 weeks ago from the NIH, and showed us that wonderful chart of a couple of years he had one or two little places on the genome he could point to for type 1 diabetes and then he went through the changes that have gone on the first quarter of 2008. Virtually the whole slide was filled up with little colorful things on the human genome. We are going to have an era of medicine where the ability to predict a predictive profile is going to be significantly different from what it was in the years that I practiced medicine. We need to preserve the ability to have that type of personalized medicine that high touch as well as high tech and to preserve the type of healthcare system that will nurture that and encourage that and not drive it in a direction which it should not go.

But anyway, I welcome our witnesses and I am looking forward to your testimony. I will yield back the balance of my time and look forward to a lively question-and-answer session. I yield back.

Mr. PALLONE. Thank you.

Next is our vice chair, who is a champion of healthcare professionals, the gentlewoman from California, Ms. Capps.

**OPENING STATEMENT OF HON. LOIS CAPPS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA**

Ms. CAPPS. Thank you, Chairman Pallone, for convening this hearing. Thank you to all of our expert witnesses for being with us today, and a particular welcome to Governor Corzine and our friend, Elizabeth Edwards. This topic, so important in consideration of comprehensive health reform, will help us to set the stage for enactment next year.

I believe we can agree that our next President will be tasked with finally achieving an overhaul of our broken healthcare system. Quite frankly, this current Administration has had little interest in taking any approach other than one that favors the healthy and the wealthy. This approach has had grave consequences as we have seen outcomes in the United States slip further behind outcomes in other western countries. We watch the number of uninsured Americans grow to now 47 million. We have seen health disparities grow between different ethnic and socioeconomic groups. And when we talk about health reform, our emphasis needs to be on how we can best serve the needs of all Americans, one that recognizes the specific health needs of women and of children, one that emphasizes the importance of primary and preventive healthcare and one that guarantees every American access to high-quality care. Quite frankly, this will never be achieved if we only look at healthcare through the tax code or as a commodity. Healthcare shouldn't be

a luxury; it is a right. I don't think we can accomplish anything by making comparisons to shopping around for other luxuries. I might shop around for the best price on a car or a television but if I don't find one that I can afford, I am not going to die. The same cannot be said for healthcare. So our goal here is to examine what has and what hasn't worked.

I look forward to hearing from our witnesses today on their thoughts on this matter and what they envision the ideal healthcare to look like, and I yield back.

Mr. PALLONE. Thank you.

The gentlewoman from Illinois, Ms. Schakowsky.

**OPENING STATEMENT OF HON. JAN SCHAKOWSKY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS**

Ms. SCHAKOWSKY. Thank you, Mr. Chairman. I am going to put my statement in the record because I really am anxious to hear all of our witnesses. I do want to give a special welcome to Governor Corzine and acknowledge the work that he has done to continue to expand health insurance in his State. Our Governor Blagojevich has made healthcare a priority as well but it is such a difficult challenge, and I want to also thank Elizabeth Edwards and the Center for American Progress Action Fund and for her incredible aspiration and leadership.

And finally, I am thankful to all of the witnesses but I wanted to thank the Commonwealth Fund for its work in pointing out that this is not just about the uninsured anymore, that millions and millions of families are struggling now to have the adequate insurance that they need and that it is time to have as every other industrialized country does, we make healthcare a right and provide it to all Americans, and I yield back. Thank you.

Mr. PALLONE. Thank you.

The gentleman from Arizona, Mr. Shadegg, is recognized for an opening.

**OPENING STATEMENT OF HON. JOHN B. SHADEGG, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ARIZONA**

Mr. SHADEGG. Thank you, Mr. Chairman, and I will put my formal statement in the record. I do want to compliment you for holding this hearing and I want to thank all of our witnesses.

Throughout my career in Congress, from my election in 1994 forward, I have worked on healthcare reform. I believe that there are many great things to say about healthcare in America but there are many things that we can do much better than we do now. I began my career fighting for patients' rights because I believe the HMO industry was in fact shortchanging patients or people in America who needed healthcare for not the best of reasons, for money reasons. But I think we face a huge issue in how we reform healthcare in America. I think we can in fact make it dramatically better.

I would argue that it was the law of unintended consequences that has led us where we are, and that is, the Federal Government, the United States Congress a number of years ago basically said healthcare provided by your employer is tax subsidized, it comes with pre-tax dollars. Healthcare you go buy yourself has to be paid

for with post-tax dollars. That slaps down rather, I think, outrageously the poorest of Americans who can't get healthcare through their employer. We say to them, well, you ought to be insured, you shouldn't show up at a hospital emergency room without healthcare, but oh, by the way, you have to buy it with post-tax dollars, meaning it is at least a third more expensive. That is outrageous and it is wrong and I have been fighting to change it since I got here.

We also have said in America under ERISA that if a healthcare plan, not a doctor but if a healthcare plan makes a negligent decision, they are immune. Indeed, I can cite you lawsuits where the government specifically says in a decision decided by the U.S. Supreme Court that if a plan denies you care and it results in death or injury, that plan is immune from damages, but if a doctor makes the same mistake, well, you can scare the bejebees out of him.

I think we are at a pivotal moment. Right now, healthcare in America, I believe, is controlled by third parties. Your employer picks your plan because the government says it is tax subsidized if that is how it happens, and then the plan picks your doctor. You, the individual patient, can't hold that plan accountable, you can't demand better service, you cannot demand lower price. You are just at the mercy of the plan your employer picked and you are left out of the process. Now, we have a choice. Do we go to more third-party control by creating what my colleagues on the other side want, a universally run government-run program where you are a cog and you fit into the program and instead of having your employer make your healthcare decisions for you, some government bureaucrat does, or do we say you know what, we should empower people, we should let people make choices, we should give people the money that the employer has right now and let them make a decision. They should take the money from their employer or, I would prefer a tax credit from the government and buy either their employer's plan or some other plan they choose. Put them in charge. And for poor Americans, my legislation says we give them a refundable tax credit and even the poorest in America can go buy a plan that responds to their demands and their needs and their interest and we give them choice to go buy the plan they want. Then they can demand that that plan provide them quality services at a low price or they will fire them and go buy another one. If you turn on the TV tonight, you will see 20 commercials for auto insurance. You will not see a single commercial for health insurance because health insurance companies don't have to market to people.

Now, how do we take care of those with preexisting conditions? I have introduced and this Congress thankfully has passed State high-risk pools. Sadly, the States have not taken advantage of those, but we can write high-risk-pool legislation that says to insurance companies, you are going to help fund the high-risk pool in your State, you are not going to put people in there that shouldn't be in there because you will be required to pay the cost of it but we are not going to let anyone in America go without healthcare. I have dropped a bill that will do that. We can ensure that every American has healthcare but every American has healthcare they choose, not healthcare——

Mr. PALLONE. The gentleman is over by 1 minute.

Mr. SHADEGG. I am almost finished. Not healthcare picked by a bureaucrat and controlled by a bureaucrat.

Thank you, Mr. Chairman, for your indulgence.

Mr. PALLONE. Thank you.

I now recognize the gentlewoman from California, Ms. Solis.

**OPENING STATEMENT OF HON. HILDA L. SOLIS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA**

Ms. SOLIS. Thank you, Mr. Chairman. I also want to thank our panelists for being here. I welcome you, Governor Corzine, and also the honorable Elizabeth Edwards for being so courageous and a healthcare advocate for so many, many people across this country.

I want to focus my attention on the disparities that exist in healthcare, particularly among the Latino community. We find that there are currently about 15 million Latinos that don't have insurance but many of these families are working families, and believe it or not, many of them are U.S. citizens, but they have not been able to access some of the fine programs that we have currently in place like Medicare, Medicaid, and also the SCHIP program. In my State of California, we continue to fall behind in terms of outreach to these communities, particularly because we have problems with barriers in English, cultural, linguistic barriers, and the fact that the governor in our State has cut back and has not, in my opinion, utilized funding appropriately to reach out to these communities. We do have a healthcare crisis, not just with the Latino community but with African-Americans and also Asians. These are the groups that will soon represent in a few years 50 percent of this country, and what are we doing to help provide them with better healthcare outcomes? That is a big question.

I don't want to lecture anybody and I don't want to be lectured at but I can tell you that I am looking forward to a Democratic leadership in the coming year and I am hopeful that we will see an expansion of these programs, the SCHIP program, and that we make an investment, a human resource investment, in communities of color. Not just providing them better access to services through public health care clinics and what have you but also investing in their education so that we can have professionals that will serve in our communities and want to stay there and to have an incentive so that they can have some type of loan repayment to be able to work that off in communities of color and rural America and in the urban cities.

So I am hopeful that we can work together with you. I am very excited about the possibilities of the change for so many Americans, 47 million people who are waiting to see that they have some form of healthcare coverage.

So with that, I will yield back and would like to just submit my comments for the record. Thank you.

Mr. PALLONE. The gentlelady's comments will be submitted. Without objection, so ordered.

And next we have the gentleman from Texas, Mr. Green.

**OPENING STATEMENT OF HON. GENE GREEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS**

Mr. GREEN. Thank you, Mr. Chairman. I am pleased we are holding the hearing today on this crucial subject of reforming America's healthcare.

No American should be living in this country without health insurance. Yet, nationwide, 47 million Americans are uninsured. Texas, unfortunately, has the distinction of having the highest rate of uninsured in the Nation. Nearly 25 percent of the population in Texas is without health insurance coverage. Our system was designed so that every American should be covered, either through an employer-based plan or individual plan or a public plan, but as medical and insurance costs continue to rise, more and more Americans are falling through the cracks. The largest rise in uninsured and underinsured are middle-class families that make too much to qualify for public programs but who don't make enough for the costly premiums under private plans. With the economy in shambles and insurance costs rising faster than people's wages, we can expect the number to grow.

Most Americans get insurance through employer-based plans. The problem here is that the average amount employers have to pay for insurance has risen by two-thirds over the past 8 years. This means that not only are companies forced to offer fewer benefits but also that employers pay higher premiums. American do have another option besides buying into the employer-based plan. They can buy their own individual plan. But many people are averse to this because costs of individual plans are considerably higher than employer based and unfortunately many companies will screen their applicants so they come across as a higher risk. They either raise the cost or they deny it altogether. You can't truly reform the system without creating safety nets to ensure that every American no matter how sick they are has access to quality, affordable care. Many States have taken initiatives to create insurance pools for high-risk applicants. Costs are still comparably higher. The key to reform is providing affordable care to these people.

Another problem we face is getting people who are eligible for public programs enrolled. Again, in Texas, enrollment barriers have kept many people off who are eligible for Medicaid and SCHIP off the rolls. Texas HHS estimates that between 200,000 and 300,000 children are eligible for SCHIP but not enrolled. As the economy worsens, unemployment rises, States are going to continue to shoulder more of the burden. We need to find ways to support them in reforming private and public plans and support in finding innovative ways to use technology and quality care in insurance practices.

Unfortunately, the large number of uninsured creates a vicious cycle by driving up healthcare costs. The uninsured often miss preventative care and don't even seek help until problems are dire. Research by the Kaiser Family Foundation shows that nearly 40 percent of uninsured skip recommended tests or treatment. Twenty percent say they have needed but not received care for a serious problem in the past year. The cost burden on hospitals facing this problem could be avoided if American had some type of healthcare coverage and access to that care. This would lower the amount hos-

pitals pay for treating serious conditions while uninsured patients would eventually lower insurance costs for everyone. We have to reverse the risk cycle. We have to start somewhere and that is why it is so important we begin discussion of reform.

I thank our witnesses. We have a great panel today; both the governor and Ms. Edwards and a lot of folks we have worked with and I hope the next Congress will build on what we hear today and create that safety net for all Americans to have some type of health coverage. Thank you.

Mr. PALLONE. Thank you, Mr. Green.

I next recognize the gentlewoman from Colorado, Ms. DeGette.

**OPENING STATEMENT OF HON. DIANA DEGETTE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO**

Ms. DEGETTE. Thank you very much, Mr. Chairman. I was really heartened to hear Chairman Dingell talk about how he intends to work on comprehensive healthcare reform in the next Congress, because as we have heard from my colleagues, it is so urgently needed, and when we do look at comprehensive healthcare reform, we need to look at universality so we can cover everybody in some way. We need to look at portability so people can take it from employer to employer, State to State, and we need to look at affordability so that we can make this whole system that is groaning under its own weight more affordable both for the patients and for the system.

Having said that, Mr. Chairman, I just want to talk about two things that I think about constantly. The first one was a lady who came in and testified in front of this committee last year on the SCHIP bill. She is my constituent, and she is a janitor, she is a single mom. She was abused and she left and she has two little kids, and she is trying to go to school and she is trying to work and do what she is supposed to do, and she got a raise in her job as a janitor so then she was thrown off the SCHIP program but her employer doesn't offer health insurance so she didn't have health insurance so now she doesn't have insurance and she just went for some cancer screening and found out that she had some abnormal cells. And equally bad, she has to take her kids to the emergency room every time they get an ear infection. What kind of country is it that has that kind of healthcare for people who are trying to work and do the right thing?

The second thing I have been thinking a lot about lately is a friend of mine, he was my next-door neighbor when I was growing up and I have known him since I was 6 years old, and he called me up a couple of months ago. He is an actor and supports himself part-time by renovating houses so he is self-insured and he did the right thing, he bought insurance, and about a year ago he was diagnosed with prostate cancer. So he went in and he was treated for it, and then after the treatment, which he thought was successful, his insurance company called and said—and he was self-insured. They said we are going to increase your insurance to $1,000 a month and oh, by the way, we are excluding any future prostate cancer from your coverage. So he said, well, that is ridiculous, I can't afford it and it wouldn't cover prostate cancer anyway. Well,

you know the end of this story. About 3 months later, it turned out the cancer had spread throughout his body and he had no health insurance. So he went back to his old doctor and his old doctor said well, you don't have insurance, we are not going to treat you, and he had to apply for SSI, which my office was able to expedite for him, and now he's in the wonderful hands of the Denver Health System. But I just have to ask again, what kind of a country is it that treats our citizens that way?

So this is why we need healthcare reform, this is why it needs to be comprehensive, and I am committed to working with every single person on both sides of the aisle on this committee to make that happen.

Mr. PALLONE. Thank you.

Next is the gentlewoman from Oregon, Ms. Hooley, recognized for an opening statement.

**OPENING STATEMENT OF HON. DARLENE HOOLEY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OREGON**

Ms. HOOLEY. Thank you, Mr. Chair, and I want to thank all of the panelists for spending your time with us today. You are an inspiration to us.

And I just want to share with my colleagues our continued support for healthcare reform in this country. I think we have reached that tipping point where people now say yes, in fact, we need a healthcare system. We are bleeding, literally, as our ERs are filled with people seeking emergency care because they don't have health insurance. In fact, I happened to be at a conference where a woman passed out. There was a doctor there. He said we need to get you to the emergency room, we are going to call an ambulance. She said you can't do that, I don't have any insurance. That was just one incident. And again, I am going to repeat what my colleague said, what kind of a country is that?

We are bleeding financially and 45 million Americans are still without health insurance because they can't afford it or they don't have jobs that provide it. We are bleeding confidence because no one sees our healthcare system getting any better in its current form. Colleagues, we are bleeding to death. The band-aids that have been thrown at our healthcare system over the last 20, 30 years are failing. It is time to stop the bleeding once and for all and overhaul the way healthcare and insurance is provided in this country. It is time for healthcare reform.

There have been many ideas that have been presented on this issue. I think some of the best ideas come in the form of the Healthy Americans Act. The Healthy Americans Act provides private healthcare coverage to all Americans and makes that coverage portable and incentivizes prevention. It will also save us nearly $1.5 trillion over the next 10 years. As millions of Americans struggle in this difficult economic time, small increases in healthcare premiums, copays, and prescriptions are causing more and more stress. Under the Healthy Americans Act, lower and middle income Americans will actually save money to receive the same or better care than they currently have. Individuals could keep their coverage as they move from job to job or if they become unemployed, ill, or disabled, and the bill would prohibit insurance companies

from denying coverage to those with preexisting conditions or risky family histories. The writing is on the wall. Our system is broken and is sending individuals, families, and our country on a financial freefall at a very fragile economic time, but more than that, people's health is being jeopardized and there is nothing more important than our health.

I look forward to the upcoming debate on smart healthcare reform, and my hope is that we will start with the Healthy Americans Act. Thank you, Mr. Chair, for your time.

Mr. PALLONE. Thank you, Ms. Hooley.

The gentlewoman from Wisconsin, Ms. Baldwin.

**OPENING STATEMENT OF HON. TAMMY BALDWIN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WISCONSIN**

Ms. BALDWIN. Thank you, Mr. Chairman, and thank you to all of our witnesses for joining us today. We are really honored to have you here, and you are here to address what I believe is the most pressing crisis facing this committee, this Congress, and our Nation, and that is the need for healthcare reform.

When I first came to Congress, I came with a very clear goal of wanting to reform our healthcare system to make it accessible and available to all Americans, and to make it comprehensive for all Americans, and I am sorry to say that over the time that I have been here, the crisis has only gotten worse. Today, however, I think we stand at a critical point in our Nation's history. I don't think I have seen as much momentum for change as I feel around me right now in this Nation and I do believe that we can get the job done.

The most glaring aspect of this crisis of course is the uninsured. There are roughly 46 million Americans who do not have access to health insurance, and as we know, there is a face and a story and a family behind every single one of those Americans. They are mothers, fathers, sons, daughters, workers, and above all, Americans, and I believe that healthcare ought to be a right and not just a privilege for some.

But I also understand that our crisis is a financial one as well. We need to rein in healthcare spending if we are to build a sustainable system for the country's rapidly engaging population. As we have come so far with treatments for a wide variety of diseases, our problem is now one of chronic disease, which strains the finances of our healthcare system as well as the health of our citizens.

I have long been a supporter of States as innovators in the healthcare system and in healthcare reform and we have seen, and I am sure our witnesses can attest, that many States have successfully taken up the issue. Vermont, Massachusetts, California, my home State of Wisconsin, are only a few of the states that are exploring new avenues for healthcare reform. The Federal Government should be a partner with the States in these efforts and not hamper their innovation, and while I recognize the very great need for national healthcare reform as we move forward in the conversation about healthcare reform, I encourage my colleagues to continue to provide incentives for innovations at the State level.

It is hard to think of a more difficult challenge than taking on America's healthcare system. Literally every single citizen has a stake in the way we approach this. But I know that we need to tap into the minds of experts in the field such as the witnesses that we have before our committee today, as well as listening to the Americans that all of us represent in our districts. Only then will we be able to achieve our goal of access to healthcare for everyone. That day has been far too long in coming but we have a tremendous opportunity to change that in the very near future.

Thank you, Mr. Chairman, again, for holding this hearing and thank you to our witnesses.

Mr. PALLONE. I want to thank the gentlewoman.

I would ask unanimous consent to enter into the record a statement from Congressman Jim Langevin of Rhode Island. I think many of you know that he has made healthcare reform a major priority in this district. Without objection, so ordered.

[The prepared statement of Mr. Langevin was unavailable at the time of printing.]

Mr. PALLONE. That concludes the opening statements by members of the subcommittee, so we will now turn to our witnesses, and we do have one panel today, a very large panel, and I want to welcome all of you.

I am going to basically introduce each of you starting from my left with my governor, who I am so happy to have with us today, the Hon. Jon S. Corzine. Governor Corzine has done a tremendous job on so many levels, primarily on dealing with the budget, which is always so difficult in the State of New Jersey, but he has repeatedly said that he wants to expand healthcare for all residents in New Jersey to the point where every resident of New Jersey does have health insurance and has already begun the process of instituting that, particularly with children and low-income people, and so I do want to welcome him today. Thank you for being here. Next is Ms. Edwards, who many of you know has been a champion on healthcare reform for many years. She now is a Senior Fellow with the Center for American Progress Action Fund here in D.C., and thank you for taking the time to be with us here today. We then have Dr. Stephen Parente, who is Director of the Medical Industry Leadership Institute and Associate Professor for Finance at Carlson School of Management at the University of Minnesota. And next is Mr. E.J. "Ned" Holland, Jr., who is Senior Vice President for Human Resources and Communications with Embarq based in Overland Park, Kansas. Thank you for being here. Patricia Owen, who is President and founder of FACES DaySpa from the Village at Wexford at Hilton Head Island, South Carolina. And then Ms. Karen Pollitz, who has certainly been here many times. Thank you for being here again today, Karen. She is Project Director and Research Professor at Georgetown University Health Policy Institute. And after that we have Karen Davis, who is President of the Commonwealth Fund in the city of New York, and we have William J. Fox, who is Principal and Consulting Actuary for Milliman in Seattle, Washington, and last is Mr. Ronald Bachman, who is Senior Fellow for the Center for Health Transformation, who is from Atlanta, Georgia. Thank you, and thank you all for being here today.

I think you know that we operate with 5-minute opening statements. They become part of the record. Each witness may in the discretion of the subcommittee submit additional statements in writing for inclusion in the record, and I now recognize my governor, Jon Corzine.

**STATEMENT OF JON S. CORZINE, GOVERNOR, STATE OF NEW JERSEY**

Mr. CORZINE. It is a pleasure to be back in Washington to offer my perspective as the governor of the great State of New Jersey about the essential need for healthcare reform. I first want to say thank you to Chairman Pallone for all his great work not only here in Washington but the State of New Jersey in pushing, championing healthcare programs at large, and I also want to commend the committee, both sides of the aisle for your leadership in enacting some of the moratoriums in what I believe were decidedly harmful Medicaid regulations that were about to be imposed and issued over the last year. Those regulations threatened critical funding for hospitals and healthcare providers and severely would have impacted the vulnerable, many of which were talked about earlier. I would hope that you would work on a moratorium on the remaining regulation limiting outpatient hospital payments.

Looking forward, I am thrilled about the healthcare reform debate that is going on in the presidential and congressional campaigns. I commend the members and today's other witnesses for addressing this important national issue. Unfortunately, in the past few days in our financial markets and with respect to the national recession, whatever problems we have, they are only going to get a little worse, maybe a lot worse, quite an exacerbation of those issues and should motivate us to move even faster.

Growing economic troubles are a severe problem for our State economies and that impacts our ability to work in healthcare. You know the litany: falling home prices, rising unemployment, declining tax receipts, higher energy costs, escalating Medicaid spending, and on and on. It is clear more employers in this environment will be dropping healthcare or creating costs for the employee that are hard to bear going forward.

The Kaiser Foundation says for every 1 percent increase in unemployment, 1.1 million more people go onto the Medicaid rolls. We have gone from 4.9 percent to 6.1 percent just this year. So the problem that we have in financing this is going to grow in the context of the current environment.

As somebody who has had a little bit of firsthand experience with the healthcare system due to some of my own failings a year-and-a-half ago, I am one to say that we have much that is good in the system. It is not something that has failed in every aspect, but I think all of us have to realize that there are very large disparities in how it works for our population and it is not with equal standard that healthcare is administered to a vast number of people. I am not going to go through the 46 million, whether it is 45 or 47. It is growing. It was 40 million in 2000. There is enormous pressure. The single largest cause for bankruptcy in America comes as an outgrowth of major medical emergencies and financial crises that happen. We are spending 16 percent of the GDP on

healthcare. It is time that we get control of the costs. And if it were only the costs that were at stake, then we would have one set of problems, but the fact is that the healthcare performance outcomes is not where it should be in America, 37th, according to the World Health Organization. We have got the rankings reversed. We are paying the most and getting something less than what we should and I appreciate Chairman Dingell and Mr. Murphy's comments on some of the flaws that are in the system. We need to address those.

The question is, how do we better align our system, particularly in a patchwork of systems that really don't all fit together? The answer in brief I believe is twofold. First, we need a strong and committed Federal-State partnership willing to build on and strengthen practices of successful programs that exist along with our employer-based coverage. And second, we need federal leadership to put in place a system that provides universal access for all Americans, and this is particularly true since the Federal Government and ERISA programs are about 50 percent of all of those insured today. So we can't just deal with these programs at a State level.

As you know, I am an old washed-up businessman but I think I understand that the first lesson that you learned in medical school if you were a doctor is do no harm. In today's context when we talk about the short term, I hope we do no harm with the State programs that we already have in place. That means asking for reauthorization of SCHIP, a program that has benefited millions of children, about 260,000 in New Jersey, and for a decade this has been one of the most important building blocks at providing access to healthcare. We have 430,000 adults and with Medicaid and SCHIP, 570,000 children in our State program, FamilyCare, and this is essential for the health of our public but it is also essential that we get this reauthorization for the health of our finances in a State like New Jersey but I would say that is the case with the vast majority of the States.

Along these same lines, do no harm means increasing the federal Medicaid match, or FMAP, and this countercyclical environment, reimbursement mechanism that is absolutely essential for the kind of meltdown we are having in our finances and fall-off in tax receipts, which with very few discretionary means of adjusting budgets at State levels where we have constitutional responsibility to balance budget, we need this FMAP help and we need it now. The revenues, I think, in most States are falling off very dramatically.

And we also know that as the ranks of the uninsured grow, so does hospital emergency room utilization and charity care, and we have a crisis in the ER rooms across this country. We actually have universal healthcare in this country. Unfortunately, it is delivered at the wrong spot, in our emergency rooms. It is the most expensive spot. It is not the place for a medical home. ER activity adversely affects obviously the financial operations and we have a crisis in our hospitals. We had eight out of the 81 hospitals we have in New Jersey close in the last 18 months and we have a long list of others that are under enormous pressure. So we need to make sure that we move in these areas. I think the FMAP is one of those places that can help immediately.

We need to make sure we do no harm in how we fund and allocate the opportunity to have federally qualified health centers. It

is a great backstop. We have 80 sites in New Jersey. They are effective partners in providing preventive care and help in chronic care. I encourage you not to miss any opportunity to press forward in this area.

And then finally, do no harm means please don't stand in the way of Massachusetts or New Jersey, who are taking big steps in expanding access and have the use of flexibility in enacting insurance reforms to reduce costs to the system. Just this last spring, I signed a law that will expand our FamilyCare, which I spoke about earlier, for the 250,000 uninsured kids that we have in New Jersey. In fact, we are mandating that so we are taking an intermediate step to universal access and we put also in place insurance reforms that will help both small business and the individual market, modified community ratings, medical loss ratios, a whole series of steps that are actually trying to work in the market. We need to have that flexibility for the States to do it. We have been laboratories of change. We can be in the future but we need national help with regard to this universal healthcare coverage reality.

We need the Federal Government to provide some kind of roadmap for the ultimate guidelines and design of our program. We need to improve outcomes but we also need to promote the movement and management of chronic care and access to preventive care to get into a more cost-effective system. We need the Federal Government's leadership and investments in electronic medical record systems, setting standards, requiring best practices, establishing deadlines for implementation. It isn't going to happen if we do it piecemeal, and by the way, someone gets sick and they happen to be in another State at the same time, what have we accomplished? We need to move together as a Nation on this and we need the cooperation between the States and the Federal Government.

Just this year, we asked Professor Uwe Reinhardt of Princeton to look at our healthcare system and how we rationalize them in the State of New Jersey, and there are just so many places where we overlap between the two. One of the most important recommendations made by that commission, which I hope this committee will examine, I know the chairman is looking at it, and that is to put a cap on hospital charges for the uninsured and no more than some percentage of Medicare. We used 115 percent. We are actually ripping off the uninsured often to try to make up for the failure of the uninsured in other areas.

There are lots of flaws in the system. I could go on. Prenatal care, if we had it, we would have healthier women in pregnancy, better birth outcomes, all kinds of great things, and I encourage you to move on this universal healthcare. Across the board on every aspect, there is no question that if we provide access, we will improve the cost structure, we will improve the outcomes. This is not only a cost-benefit analysis, it is a moral responsibility. I think it is very encouraging that both Senators Obama and McCain are talking about moving in the right direction with regard to universal access. They have premises and objectives that are generally common. Both candidates want access to care to contain healthcare costs, to build healthcare IT infrastructure and encourage preventive care. We need to take these themes and use these as a basis to drive to universal access and make sure that we are leveraging

those things that are working—SCHIP, FQHCs, employer-sponsored coverage, et cetera.

We can reform this system but we have to have the will and the commitment to make sure it is done and it should be done with a Federal-State partnership. I know we are willing in New Jersey to build on that, I know the governors are, and I look forward to working with this committee in the days and weeks ahead, months ahead to come up with a system that breaks the back of a broken system.

[The prepared statement of Mr. Corzine follows:]

## STATEMENT OF JON S. CORZINE

Good morning Chairman Pallone and Distinguished members of the Subcommittee on Health.

It is a pleasure to be back in Washington to offer my perspective as the Governor of New Jersey about the essential need for health care reform across this nation.

Before I start, I want to commend Chairman Pallone, who has been a champion of critical health programs for both the State of New Jersey and the country—I thank you for your leadership.

I also would like to commend the Committee and the many members of on both sides of the aisle for your leadership and hard work in enacting a moratorium on many of the harmful Medicaid regulations the Administration issued over the past year. Those regulations threatened critical funding for hospitals and other health care providers and would have impacted severely the care provided to our most vulnerable. I would encourage, however, you to seek a moratorium on the remaining regulations limiting outpatient hospital payments.

Looking forward, I am pleased that health care reform is at the forefront of the national debate in the ongoing Presidential and congressional campaigns. I commend the members-and today's other witnesses-for their commitment to addressing what is one of the most challenging and severe problems we face: the broken health care system.

The events of the past few days in our financial markets and the national recession will likely exacerbate the stresses present in the healthcare system and will further motivate our need to work together for reform.

Our growing national economic troubles are already having serious consequences for most state economies and our finances—you know the litany—falling home prices, rising unemployment, higher energy costs, escalating Medicaid spending, and more families in need of health care services. In this economic climate, it is clear more employers will be forced to reduce or eliminate health coverage for their employees, aggravating the negative trend in employer-provided health insurance.

In fact, according to the Kaiser Family Foundation, nationally every 1 percent increase in unemployment results in 1.1 million more uninsured and an additional 1 million people—400,000 of them children-enrolling in Medicaid. And, since Medicaid eligibility lags 6 months behind unemployment figures, the full impact of increasing demand for Medicaid services cannot be known for some time.

As some of you know, I had first hand experience with the health care system when I was in a car accident about a year-and-a-half ago. I am extremely grateful for the outstanding care that I received. It was truly extraordinary. In truth, while the U.S. health system has millions of dedicated professionals providing great care and treatment, our health-care system in many respects does not match the high standards we have come to expect.

There are now about 46 million uninsured Americans—up from 40 million in 2000. We can all agree that's 46 million too many, and the number is rising every day. Far too many Americans live with the fear that a major medical emergency could mean financial ruin. In fact, health care costs are the leading cause of personal bankruptcy.

But the crisis in our health care system is much more than the number of uninsured. We rank 37th in health-system performance, according to the World Health Organization, but 1st in expenditures. Quite simply, we are paying more but getting less.

The question is: how can we better align our system—really a patchwork of systems—to begin to reverse those rankings?

The answer, I believe, is two-fold. First, we need a strong and committed federal-state partnership, willing to build on and strengthen best practices of successful pro-

grams and existing elements such as employer-based coverage. Second, we need federal leadership to put in place a system that provides universal access for all Americans.

I may be a washed-up businessman, but my understanding is that when you first enter medical school, the first lesson learned is: "Do No Harm." In today's context, during a recession that is hurting everyone, "Do no harm" means supporting State programs rather than undermining them.

Following the principle "Do no harm" means reauthorizing SCHIP, a program that has benefited millions of American children by letting states tailor their plans flexibly to adjust for wide variation in the cost of living and availability of providers. SCHIP has been a highly successful building block across the country for a decade, and should actually be expanded, particularly during a recession. New Jersey covers 430,000 adults and 570,000 children through our Medicaid and SCHIP programs, known as FamilyCare. I urge you to do everything that you can to move ahead on reauthorization of this crucial program.

Along those lines, "Do no harm" means increasing the federal Medicaid match, or FMAP, in what's called a "countercyclical" reimbursement mechanism, so that during a national downturn like our current one, States receive more money to cover the growing numbers of people losing insurance and are able to hold off harmful cuts in safety net programs. Without that support, coverage is one of the few discretionary items that states have in their financial tool box. You all must remember that states are constitutionally mandated to balance our budgets.

We all know that as the ranks of the uninsured grow, so too does hospital emergency room utilization. We really have a crisis of ER use in this Nation—it's a costly replacement for a family care physician or a medical "home", ER activity adversely affects hospital financial operations, and it is not conducive to providing the kind of preventive and chronic care that will reduce costs in the system. I can tell you we have a true crisis in financing Charity Care among our hospitals in New Jersey.

So "do no harm" does mean helping states get more people insured so they're not overusing the ER, but it also means expanding the Federally Qualified Health Centers (FQHC). In New Jersey, we have found our FQHC's—we have over 80 sites—to be highly effective partners in our efforts to expand access to essential health care services—particularly preventative and chronic care.

Finally, "do no harm" means support the innovators—a state like Massachusetts that has enacted comprehensive reform, and states like New Jersey that are taking big steps by expanding access and enacting insurance reforms to reduce costs to the system. This summer, I signed into law an expansion of our bipartisan FamilyCare program to cover more working-class families while mandating health coverage for all children—250,000 of whom are currently uninsured. We also enacted insurance market reforms to make health insurance more affordable to individuals and small businesses in the State.

I think I can speak for my fellow Governors on both sides of the aisle when I say that most states, for so long the laboratories of change, need immediate help to get through this recession if we're to remain the reliable source for health care we have always been. And going forward, we will need a strong federal-state partnership to make our vision of universal health care a reality.

I believe states have been creative in devising strategies to cover more people while holding down costs. But federal support is absolutely necessary if we are going to achieve truly universal care. It may come down the road, and it may have to happen in steps, but that ultimate goal should guide the design of our reform. We all know those with insurance receive better care, and that higher levels of coverage translate into lower health care costs as people manage chronic diseases and access preventative care. The federal government can coordinate this effort in a way that reaches the most people and is the most cost-effective.

Federal support means investments in a national Electronic Medical Record system—setting standards requiring best practices and establishing deadlines for implementation. This is a perfect example of where the Federal Government can coordinate a cost-saving mechanism that would mean better quality care for all Americans and billions in reduced health care costs.

In New Jersey, we have taken significant steps to reform our health care system. I recruited internationally recognized health care economist, Princeton University Professor Dr. Uwe Reinhardt, to lead an in-depth analysis of the complex problems that have led to a series of hospital closings. The findings of the Commission on Rationalizing Health Care Resources have resulted in a series of laws that have strengthened our hospital system, increased protections for the uninsured and put New Jersey in the forefront of health care reform.

We recently completed a study in New Jersey that showed the No. 1 barrier to women getting prenatal care is lack of health insurance. We know that prenatal

care helps women have healthier pregnancies, better birth outcomes, and gives children a better chance at a healthy life. Is there a better reason for us to fight for universal health care?

Across the board, on every aspect of care, there's no question that providing access to affordable health insurance is not only the direction that we should take-it is our moral responsibility.

On the principles, I believe most of us agree. If you review the Obama and McCain health care plans from the standpoint of premises and objectives, the level of agreement is remarkable.

Both candidates want to expand access to care, to contain health-care costs, to build health-care IT infrastructure, and to encourage preventative care. Those themes represent major common ground from which to work toward national health reform.

We ought to leverage that consensus, but we ought not to undermine what already works: S-CHIP, FQHCs, employer-sponsored coverage, and finally, state customization-whether it's with Medicaid and SCHIP or the state regulation of insurance markets, which is critical for consumer protection.

We can reform this patchwork system, but it requires a strong and committed federal-state partnership premised on a willingness to build upon what's working and a commitment to the attainability of that ultimate goal, universal care.

Thank you.

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Mr. PALLONE. Thank you, Governor, and thanks for what you do in our State, but I also want to mention, because you reminded me at the end there, of all your work as the Democratic chair of the health subcommittee for the National Governors Association. You worked on a bipartisan basis when we were trying to move on SCHIP and a lot of the initiatives and you helped us a lot with that, so thank you.

Next is Ms. Edwards. Let me just say again that the fact that you have been so high profile on this issue I think has been so important, not only to this committee and its efforts but nationally. I know that when you are in the spotlight there are a lot of different things you can talk about or work on and we appreciate the fact that you have taken so much time to profile the need for healthcare reform. Thank you.

**STATEMENT OF ELIZABETH EDWARDS, SENIOR FELLOW, CENTER FOR AMERICAN PROGRESS**

Ms. EDWARDS. Thank you, Chairman Pallone and Ranking Member Deal and members of the committee. I really do thank you for the opportunity to be here, not just because I think healthcare reform is such an important issue but because I know it is from my travels around the country. One of the reasons it is impossible for me not to do this work is because of how many voices I have heard.

I want to mention one as I start. In March of 2007, I was in Cleveland when a working woman whispered in my ear, I am really afraid for myself and for my children because I have a lump in my breast, but I cannot get treatment, I cannot see a doctor, I have no insurance. It is a very sad story because if she doesn't get treatment, the likelihood is that, Sheila is her name, that she would die as a result of this untreated condition. But as sad as it is, it is also inspiring because she took the time to whisper in someone's ear, because in America we are hopeful that we can solve these problems. She believed if she whispered in the right person's ear, that things could change. I am also hopeful that things can change.

For the first time in 15 years, we are talking about healthcare now on a national level and here in this committee. Both the Re-

publican and the Democratic nominees are engaged in a discussion about healthcare. If you looked at it from altitude, you would assume we were standing at the edge of healthcare heaven. I hope that is the case.

Given the limited time and the impressiveness of the panel sitting here, I want to just limit my comments to a couple of things. One is an analysis of the conservative approach to healthcare reform, which has been talked about by a number of people on the committee and I am certain will be talked about by a number of the witnesses before you, and to use Senator McCain's proposals as the springboard for that discussion.

Any healthcare effort that we have has to focus on achieving coverage for all and has to focus on getting costs controlled as an essential feature of healthcare. They have to happen at the same time. In fact, they are both different sides of the same Rubik's cube. We can't solve the problems on one side without also solving the problems on the other. It is a false dichotomy that pits one of these against the other. I do think that Senator McCain's policy does focus excessively on providing a lower cost policy without at the same time guaranteeing a basic level of coverage in that policy or addressing the scope of inclusion for all Americans. Any insurance operates more efficiently—any insurance, fire insurance, health insurance, car insurance operates more efficiently—the larger the number of people included in the pool so the more of us that are included, the more efficient and the lower cost the healthcare system is going to be.

It also works best for us individually when it is continuous and coordinated. By allowing people to slip in and out of the system, we reduce their healthcare status and we in fact raise the cost. As a Brookings Institute economist has noted recently, broadly expanded coverage is a precondition for effective measures to limit overall healthcare spending. Karen Davis, who is on the panel today, has also been a powerful voice on the link and I expect you will hear a lot more from her about a link between universal coverage and cost containment in talking about the importance of offering continuous coverage to contain costs and to not interrupt the access of patients and the ill to care.

If we as a country can ever agree on the need for coverage for all, then the next question is, what kind of coverage is it that we want. The larger the pool, the more efficient the system. The group market is more efficient than the individual market. I know it was mentioned by members of the committee that individual choice is really important. The truth is, we have tested that. We are testing it today. We have people in the individual market today and what we find is that their care is more expensive, that their cost-sharing obligations are higher and that there are in fact more exclusions. We also find that insurance companies cherry pick, that for the insurance companies it is more expensive because they are cherry picking among us. So we have already tested this idea. The idea that everyone can pay a little over time and across populations in return for medical care and financial security when things go wrong is the way in which we need to proceed.

So again, let us consider Senator McCain's approach as the ideal in the conservative approach to healthcare. The individual market

makes it more difficult to get insurance. Even Americans seeking coverage on the individual market with minor preexisting conditions, let alone chronic conditions, will pay higher premiums. I have said and gotten tremendous coverage for saying that Senator McCain and I have something in common, and that is, neither one of us would be insured under his healthcare plan, because the problem is, if you have a serious chronic condition, you are not likely to be offered, as was found in Denver by the young man with prostate cancer, if you are provided coverage at all. The individual market is notorious in its poor provision of coverage.

Senator McCain promises $2,500 for an individual, $5,000 for a family tax credit to help us pay for health insurance on our own. For some, that is for young healthy families and small families, the tax credit may be enough as long as you stay young and healthy, and I would like to know the prescription for that, you are likely to be able to continue to afford a policy. If you are 55 and healthy, it will cost you as much as three times that to buy an insurance policy. If you are 55 with hypertension or, as Senator McCain and I, with cancer, good luck to you.

Even if a family in an individual market is offered insurance, there is no guarantee that they can keep it. One California healthcare plan recently agreed with State regulators to reinstate 950 people who had their coverage canceled once they needed it. Chairman Waxman has held a hearing on this recently, which was very edifying.

Senator McCain's approach to deregulation on benefits would allow insurance to be sold nationally, thereby eliminating State protection of mandated benefits. So what difference does it make to me which State offers my health insurance policy? Actually it makes a lot of difference. Most people don't know what protections are currently required by their State regulations. They only know what their own policy says. But what difference does it make to me in which State it is written? Well, actually it matters a lot. It is far too easy for people to fall between the threadbare patchwork of protections offered by some States and the federal HIPAA law, especially where individuals are concerned. In only 44 States do state regulations require your health insurance policy to cover emergency room visits, only 44; six do not. Forty-five States require mental health care to be covered; five do not. Twenty-seven require coverage for diabetes treatment. When insurance companies are deciding from which State they are going to offer insurance policies, do you think they are going to be offering it from one of those 27 that require diabetes coverage or from one of the ones that do not? I think we probably know the answer, and our experience with the credit card industry is edifying in this respect. It is not too farfetched to suggest the insurance companies are going to write their policies from the most industry-favorable States, just as banks and credit card companies do.

Also, in Senator McCain's plan, marketing and underwriting costs in the individual market will be driven up. One of the complaints about for-profit health insurance companies are the administrative costs associated with each policy, that is, the part of your premium that goes into the insurance company offices in salaries and underwriting and marketing and therefore doesn't go into your

healthcare. In individual policies, the administrative costs are close to three times what it is for employer-based policies. Recent analysis shows this will likely mean $20 billion in additional administrative costs, which means an ever-larger chunk of healthcare dollars that are not going into healthcare. This is exactly the opposite direction that we want to go. Some of that is just the hassle of a large entirely diverse group but most of it has to do with underwriting and marketing, that is, determining how much risk you are and trying to find customers who don't represent much of a risk, that is, cherry picking our population, also something we want to discourage as opposed to encourage. The insurers have the incentive at the present time to play a game of musical chairs where they can hope that some other insurers get the bill for the sickest patients. This is an immoral gamble that we know is going on, that we know exists and that we allow to continue. The costs are paid by people like 17-year-old Natalie Sarkeesian from California, whose insurer her denied her a liver transplant that was recommended by her doctors. She died waiting to contest that decision.

Also in Senator McCain's plan, the marketing and underwriting costs in the individual market driving up, we also find that we are going to see additional cost-sharing ramifications by moving to the individual market, cost-sharing being your deductibles and your copayments. The cost sharing in the individual market is often considerably higher than it is in the employer provider groups. Consumer-driven care with its high deductibles creates a problem where very often the patient is required to pay the first dollar of any care. What this does is create a disincentive for people to get the care that they need. You don't get that continuity of care, conditions worsen and the cost to the overall system is increased in the long run.

Much of the disagreement between the role of the individual market and the group market rests with the belief of free-market economists that buying healthcare is akin to buying any consumer goods. I thought that the reference to the television set, I don't die if I can't afford the television set I want, was incredibly apt and I expect to be using it in the future as I talk about this. Yet deciding between the costs and benefits of various cancer treatments like chemotherapy or radiation or surgery will simply never be the same as deciding between a Dodge or a Buick or a Ford.

We have extreme market failures in healthcare that require government intervention such as the incentives for insurance companies to cherry pick, as I mentioned before, or later drop from coverage those who are sick as we heard earlier, the moral hazard faced by individuals who choose not to get coverage for themselves or their children. Simply put, it is a dangerous mistake to overstate the role that consumers can play in healthcare. It is not the same market as any other consumer goods. We are not selling toilet paper here. We are not selling televisions. We are selling an essential part of people's lives and it needs to be considered in an entirely different way.

The use of tax credits is one of the mechanisms that cuts across the political spectrum. Progressives and conservatives have both talked about their use. From the progressive point of view, tax

credits are used in conjunction with strengthening both public and private health insurance through the expansion of Medicaid and the SCHIP program. The Center for American Progress is one of the first think tanks to release a major paper on Senator McCain's plan but now there is growing consensus about what that plans means. The tax credit that he offers simply will not cover the cost of insurance except for the very smallest group that I talked about, the young and the healthy smallest families. The family premiums for employers that employers pay for insurance are roughly about $13,000 a year. A $5,000 tax credit falls well short of that amount, in addition to which Health Affairs magazine suggested that individuals moving from the employer-based policy to an individual policy of the same caliber will find that their healthcare costs have gone up about $2,000, so we would then be talking about an even greater shortfall. The tax credit is not indexed to premium increases. It is indexed to inflation. It is expected to be about 2 percent a year while premiums go up 7 percent a year. So even though there is a very small sliver of people who are tax winners in that first year, those evaporate quickly after the first year as their savings are eaten up by the increase in premiums.

Also, the tax credit is not large enough for families. Five thousand dollars for a family may do it for a very small family but will not do it for a larger family, and there is no distinction made between large families and small families.

Mr. PALLONE. Ms. Edwards, you are about 8 minutes over.

Ms. EDWARDS. I apologize for that. I will stop and answer any questions at a later point. I do think that this is an enormous opportunity and I would hate for us to miss the opportunity again to get the kind of healthcare that is going to make a difference for people like Sheila. She whispered in my ear. She is now whispering in yours.

[The prepared statement of Ms. Edwards follows:]

Center for American Progress
Center for American Progress Action Fund

**Testimony**
**For the Hearing Entitled**
**"America's Need for Health Reform"**

Elizabeth Edwards

Senior Fellow
Center for American Progress Action Fund

Before the

**Subcommittee on Health**
**Committee on Energy and Commerce**
**United States House of Representatives**

**September 18, 2008**

Chairman Pallone, Ranking Member Deal, and distinguished Members of the Committee, I thank you for the opportunity to testify on the topic of health care reform.

We are in the middle of a great debate on health care in the United States. We see it in the major debates led by Massachusetts and California. We see it discussed in more than a dozen states from Maine to New Mexico. We see the health reform debate in the many bipartisan and strange bedfellow efforts that have developed. We see the debate in the reform collations that have formed, such as HCAN and Better Health Care Together. And lest we forget, the debate is happening at every kitchen table in the country, since health costs are part of our economic meltdown. Of course, some on this committee have been a part of the fight for better health care for a long time, and I'd like to thank Mr. Dingell in particular for his leadership.

But for the first time in 15 years, there promises to be a major health care debate here in Congress. Both the Republican and Democratic nominees for president have engaged in a serious health care discussion. Everyone here knows the twin problems of our broken status quo:

- *45 million uninsured.* Health insurance is how we access care in the United States today. It is virtually the first question you are asked when you call a physician's office or go to the hospital.
- *Skyrocketing costs.* The cost of our health care system is astronomical and constantly growing. Total health care spending in the United States doubled between 1996 and 2006, and without reform is expected to double again in the coming decade.

Given the limited time and the impressiveness of the panel, I want to use my time to talk about the importance of health reform to:

- *Address Health Care for All and Cost-Containment Simultaneously.* Effective cost containment requires that everyone have coverage, and covering all requires that coverage must be affordable.
- *Strengthen the role of the group market.* Grouping health risk in the market place through employer-based benefits is one of the few things we do well in the U.S. health

system. Use of the individual market will undeniably weaken care delivery as more Americans become subject to pre-existing exclusions, higher cost-sharing, and absent benefits.

- *Use care in exploring tax credits.* Reforming the tax treatment of health insurance may be an important part of health reform. However, done poorly, it could actually diminish Americans' access to coverage. For a health insurance tax credit to work properly to expand coverage, it must make meaningful insurance coverage affordable, reflecting both family size and the rate of medical inflation. And it must not threaten employer-sponsored health insurance, which most Americans have and want to keep.

**Addressing Coverage for All and Cost-Containment Simultaneously**

Health reform will be the most successful when we try to achieve coverage for all and cost-containment at the same time. In fact, the two are on different sides of the same Rubik's cube. We'll only solve both problems at the same time, and I would encourage the Committee to think about health reform as a need to aggressively pursue both.

There is a false dichotomy held by some that there is an either/or choice in health reform—that either we achieve coverage for all first or that we will attempt to contain the sky-rocketing costs first. The extremist version of this view holds that cost-containment should be the only goal because the system is so broken and expensive that the government can't take steps to cover more people. But this approach misses the point entirely. The question is not whether we can afford to ensure that all Americans have health coverage. The question is whether or not we can afford to leave people behind.

Health insurance works best when it is continuous. Disease management and prevention are not short term or intermittent activities. Even short periods of uninsurance can lead to diminished health status as individuals lose access to the care they need. In addition, continuous health coverage is the key to coordinated care. Care delivery in our health care system is already highly fragmented, with many patients receiving care from multiple providers, particularly high users of

care such as the elderly and those with chronic conditions. This is a top cost driver that we can only address by continuous, coordinated care. Study after study has found that we can contain health care costs through better management of chronic disease.

Coverage for all will also help contain costs by reducing cost shifting and thus bringing some measure of sanity to how we finance our health care system. As a Brookings Institute economist has noted, broadly expanding coverage is "a precondition for effective measures to limit overall health care spending." In addition, Karen Davis of the Commonwealth Fund, who is a panelist today, has also offered very effective analyses on the link between coverage expansion and cost-containment.

**Strengthen the Role of the Group Market**

If we as a country can ever agree on the need for coverage for all, then the next question is what kind of insurance.

It is a fact that, in our health insurance system, the group market is more efficient than the individual market. Insurance works on the fundamental premise that risk is shared across a broad range of people. The idea is that everyone can pay a little over time and across populations in return for medical care and financial security when things go wrong.

Our health insurance markets began with employment-based coverage, and the group approach remains the central principle of our health care system today, with 60 percent of the non-elderly in employer sponsored insurance. Grouping risk is also the principle behind public programs like Medicare. And, it is the basis of health plans like that proposed by progressives, who talk about the importance of creating insurance connectors or clearing houses as a means of bringing people together to buy insurance as a group.

In contrast, conservatives have talked about promoting, and deregulating, the individual market for health insurance. Their approach:

- *Limits coverage.* While risk on the group market is pooled through employer groups, the individual market is fundamentally different. Insurers must assess the risk of each individual applicant, using medical underwriting to guess at how expensive their care will be. There is an obvious business incentive to cherry-pick just the healthiest of applicants. Americans seeking coverage on the individual market with even minor pre-existing medical conditions, let alone chronic conditions, will pay higher premiums—if they are offered coverage at all.

  And even if a family on the individual market is offered insurance, there is no guarantee they can keep it. California has a highly regulated market, and yet thousands of people have had their coverage cancelled after they filed claims. One California health plan recently agreed with state regulators to reinstate roughly 950 people who had their coverage canceled once they needed it. Chairman Henry Waxman recently held an Oversight and Government Reform Committee hearing examining this critical problem of rescissions.

- *Eliminates benefit protections.* State governments mandate benefits be included in benefit packages, something that has been cited by conservatives as increasing the cost of insurance and placing it out of reach. Certainly, if we looked at all required benefits across all 50 states, anyone could one provision of one law somewhere. But for insurance to have any value, it needs to cover the treatments and services people need and deserve. We have rules because the insurers have the incentive to play a game of musical chairs where they all hope some other insurer will get the sickest patients.

- *Increases paperwork costs.* The individual market is simply more administratively expensive than the group market. This is obvious. The marketing and underwriting costs alone drive up costs.

- *Increases cost-sharing.* No one benefits from health insurance they can't afford to use. And cost sharing on the individual market is often high. Consumer-driven care, with its high deductibles and requirements for individuals to pay "first dollar" for any care is increasingly prevalent. This type of cost sharing creates a disincentive for patients to seek the preventive care and disease management services that help control costs and improve health in the long run. It is a particular problem for those with chronic disease, and thus significant need to access the system.

Much of the disagreement between the role of the individual market and the group market rests on the belief of free market economists that buying health care is akin to buying any consumer good, like a car. Of course, individuals have a role to pay in the health care system, and we need greater transparency in pricing, quality of care data, and comparative effectiveness information to help them play that greater role. But the reality is that deciding between the costs and benefits of various cancer treatments like chemotherapy, radiation, and surgery will simply never be the same as choosing between purchasing a Dodge, Pontiac, and Lincoln. We have extreme market failures in health care that require government intervention, including:

- *Incentives for insurance companies to cherry pick (or later drop those from coverage who are sick).* Private insurance companies will always try to limit their losses by avoiding giving care to those who need it.
- *The moral hazard faced by individuals who may choose to not get coverage for themselves or their children.* Because of the cost of insurance, some individuals and their families will gamble that they can avoid getting sick to avoid paying premiums.
- *Fee-for-service incentives for providers instead of incentives that reward prevention and wellness.* We continue to fail to put sufficient emphasis on chronic care and disease management in our health care system.

In short, it is dangerous mistake to overstate the role that consumerism can play in health care that will cost lives if we get it wrong.

**Use Care in the Possible Use of New Tax Credits**

Tax credits are one of the mechanisms that cut across the political spectrum. Progressives and conservatives both have talked about their use. From the progressive point of view, tax credits are used in conjunction with strengthening both public and private health insurance through expansion of Medicaid and the State Children's Health Insurance Program, two very effective programs. The tax credits are also designed as subsidies that would limit premiums to a given percentage of income to truly help ensure that health care is affordable.

In contrast, conservatives focus on tax credits to the exclusion of other types of expansion. Also, instead of focusing on limiting the cost of the premium to individuals, the tax credit is typically fixed and unrelated to the cost of insurance—leaving individuals to cover the cost left over by the credit. Tax credits must be sufficient size to make insurance affordable for them to even be considered as an approach.

**A Chance Not To Be Missed**

I can only imagine what would be different today if health reform had been sucessful in 1993-1994. Would we have millions of uninsured today? Would we have so many companies taking their jobs and capital oversees? Would we be losing more than a $100 billion a year in economic productivity? Would we have more than 25,000 citizens a year who die because of they are uninsured? What we do know is absent health reform, all of those things will continue to be true. I will do everything I can to help this Committee with the critical role it will play on health reform, especially on patients' rights and protections. We cannot miss the chance to get health reform right. We can and must take advantage of this opportunity and get this right for the American people.

Mr. PALLONE. Thank you so much. I appreciate it, and sorry to interrupt you.

Ms. EDWARDS. No, it is all right. I apologize. As I was looking at this, I was not looking at the time.

Mr. PALLONE. I understand, and we do really appreciate your being here today. Thanks so much really.

And next I am going to go to Dr. Parente.

**STATEMENT OF STEPHEN T. PARENTE, PH.D., DIRECTOR, MEDICAL INDUSTRY LEADERSHIP INSTITUTE, AND ASSOCIATE PROFESSOR OF FINANCE, CARLSON SCHOOL OF MANAGEMENT**

Mr. PARENTE. Thank you, Chairman Pallone and Ranking Member Deal. I am honored to be part of this panel.

Let me give you some information that I found from doing research in the field. I want to start by saying that there is a tremendous opportunity in front of us if we are faced with changing the healthcare system and we have basically zero resources to do it, and what I am going to be focusing on and one thing that has been mentioned by Elizabeth Edwards and others is the purchase of insurance across State lines.

It is well known that small businesses are a critical economic engine of the United States. Even more than before these businesses can be virtual enterprises operating in multiple States and countries where human capital and expertise is tied together by e-mail, Web meetings, air traffic, and billed to order service support and manufacturing. One visit to a w=Web site today can equip an entire multi-State startup with vital technology, banking services, or travel arrangements. But with health insurance, the situation is quite different.

In the United States today, a small company or individual can only buy insurance offered in the State where they live. This policy stretches back to the Supreme Court ruling in 1944 finding insurance was not commerce under the law and that the Court would follow the lead of Congress. As a result, on March 9, 1945, the McCarran-Ferguson Act was passed by Congress. It allows State law to regulate the business of insurance, any insurance, without federal interference. As a result, each State's insurance commissioner or like official would be responsible for oversight of insurance company practices including fair and timely payment as well as premiums. This policy makes sense in the context of consumer protection, many of the issues that Elizabeth Edwards mentioned. To enforce such protections requires oversight and clear lines of communication. In 1945, these activities were best considered local. However, life in America has changed a lot since the mid-20th century.

So for this, I bring out my illustration. I did not write this book. This was given to me as a gift. It is from my alma mater, Johns Hopkins University Press, where Karen and I spent some time together, "Night Trains: The Pullman System and the Golden Years of American Rail Travel." So if I were to come to you in 1952, there is a section in the back that says where every single train is on the track on midnight, March 1, 1952, and there are literally thousands of them. It is a review of a world that just simply doesn't

exist anymore. To get to you today, I would have taken a train from Minneapolis to Chicago on the Sioux Line, gotten in yesterday morning, and then left on a train on the Pennsylvania Railroad to come in to see you this morning at 7:30 on a Pullman service. Just one example of how things have changed. The first consumer-initiated long-distance telephone call was completed in 1951. Blackberry back then was a jam. And about the time McCarran-Ferguson was passed, tuberculosis was one of the largest causes of death in the United States, surpassing cancer.

Another change is the case of health insurance. Today just over 55 percent, or more than half of all Americans, with private insurance get it through large employer-funded plans, as we know through ERISA. This came from 1978 legislation. They exempt them from McCarran-Ferguson. That means that all State-specific insurance mandates are not enforceable to the majority of Americans. For those in political science, the median voter does not apply to the majority of Americans because of ERISA.

Economists like to measure the value of goods and services as an opportunity cost, that is, the cost of foregoing alternatives. A moderate estimate of the opportunity cost of not being able to buy insurance across States lines completed in a study by myself and colleagues at the University of Minnesota—Roger Feldman, Jean Abraham and Yi Xu—estimates that between 10 to 15 million people could buy insurance if they were to purchase insurance across State lines under different policy assumptions. The one that we focused on was a moderate estimate, where people can focus on four regions where States most likely to be chosen would be Alabama, Arizona, Nebraska, and New Hampshire. Even if you were to basically concentrate the enforcement mechanisms of the five largest States in the union, you would be looking at 7 million people that would now have health insurance.

Buying health insurance across States lines is not a new policy. Members of Congress have brought this proposal forward. With the use of the Internet, it is easy to see intuitively why this policy makes some sense. On ehealthinsurance.com, a family of four of exactly the same age and gender profile in eastern Pennsylvania, say New Hope, Pennsylvania, in Bucks County, will have a premium half of what an identical policy would cost just across the Delaware River in Lambertville, New Jersey, and I applaud what you are doing, Governor Corzine, to change that situation but it is true today, just if we look today, where those premiums are. I look forward to those changes.

Purchasing insurance across States lines could be the first pragmatic step toward making the health insurance market work for all Americans. It has interesting appeal. It could be immediately acted upon with budget neutrality. The policy change is also more consistent with the United States preference for gradual improvements in insurance access.

There are many serious issues as well. Actually, I want to come back to that. People like us are sitting here and have sat here for 90 years. This is a recurring story. And every time the dial turns, another 10 or 15 million or 10 or 15 percent get something. Hopefully we will get more than this time but it is a recurring story.

It could also be said that the opportunity cost of the legacies of 1940s legislation may be leading millions uninsured with an emphasis on the word "insurance," that is, to cover high risk, very, very expensive cases such as cancer, not what we see today as health plans, which have a very gray distinction between what is necessary and unnecessary. Care for catastrophic stuff should be covered under insurance. Going beyond that is the moral hazard problem that if you actually as I have looked at the data and see why our costs grow so much, it is not because of cancer. It is because of our own greed thinking that we can live forever—a personal statement.

As we look for cures to our health policy concerns and consider our national financial resources, particularly in the last few days, the research of my colleagues and myself at least offer an opportunity that I think should get some discussion. Thank you.

[The prepared statement of Mr. Parente follows:]

## STATEMENT OF STEPHEN T. PARENTE

It is well known that small businesses are a critical economic engine of the United States. Even more than before, these businesses can be virtual enterprises operating in multiple states where human capital expertise is tied together by email, web meetings, air travel and build to order service support and manufacturing. One visit to a web site today can equip an entire multi-state start-up with vital technology, banking services or travel arrangements. But with health insurance, the situation is quite different.

Currently, a small company or individual can only buy insurance offered in the state where they live. This policy stretches back to a Supreme Court ruling in 1944 (United States vs. South-Eastern Underwriters Association (322 U. S. 533)) finding insurance was not commerce under the law rested with Congress, and that the Court would follow the lead of Congress. As a result, on March 9, 1945, The McCarran-Ferguson Act was passed by Congress. It allows state law to regulate the business of insurance without federal government interference. As a result each state's insurance commissioner, or like official, would be responsible for oversight of insurance company practices, including fair and timely payment as well as premiums. This affects the provision of all insurance, not just health insurance.

The policy makes sense in the context of consumer protection, but life has changes a lot since tuberculosis was one of the largest causes of death in the United States and the majority of interstate travel occurred on overnight trains. How much change? In the case of health insurance, just over 55% or more than half of all Americans with private insurance get it through large employer funded plans that have been exempt from McCarran Ferguson since the 1978 Employee Retirement Income and Security Act. That means all those state-specific insurance mandates like 'no drive-by deliveries' are not enforceable to the majority of Americans.

Economists like to measure value of a good, service as opportunity costs, the cost of forgone alternatives. A moderate estimate of the opportunity cost of not being able to buy insurance across state lines is 10.5 million uninsured per year. These estimates are based on a study recently completed by myself and colleagues Roger Feldman, Jean Abraham and Yi Xu at the University of Minnesota (see: http://www.ehealthplan.org). The estimate assumes people will buy insurance in one of four regions where one state has the lowest regulatory burden in terms of coverage mandates, guaranteed issue of insurance and community rating of premiums. Those four states are Alabama (South), Arizona (West), Nebraska (Midwest) and New Hampshire (Northeast). Other models assume only the five largest states are available for interstate insurance offers and find a moderate estimate of 7 million newly insured.

Buying health insurance across state lines is not a new policy proposal. U.S. House of Representatives and Senate members have advocated this policy in repeated legislative sections. With the use of the Internet, it very easy to see intuitively why this policy would make sense. On ehealthinsurance.com, a family of four with exactly the same age and gender profile in eastern Pennsylvania will have a premium half of what an identical policy would cost just across the Delaware in Washington Crossing, NJ.

Purchasing insurance across state lines could be the first pragmatic step toward making the health insurance market work for all Americans. It has interesting appeal. It could be immediately acted upon with budget neutrality. The policy change is also more consistent with the Unites States preference for gradual improvements the health insurance access. There are many serious issues as well such who would be ultimately accountable for consumer protection. At best it would be two states, but coordination could be onerous. It is understandable why state specific preferences have played such a major role. But it can also be said that the opportunity cost from the legacy of 1940s era legislation are millions of uninsured left to live (and perhaps die) from personal distress and devastation. As we look for cures, and consider our national financial resources—this policy option needs more serious consideration.

# Consumer Response to a National Marketplace for Individual Insurance



Final Report
June 28, 2008

Stephen T Parente, Ph.D.
Roger Feldman, Ph.D.
Jean Abraham, Ph.D.
Yi Xu, B.A.

CARLSON
SCHOOL OF MANAGEMENT
UNIVERSITY OF MINNESOTA

# Consumer Response to a National Marketplace for Individual Insurance

## Introduction

Federal lawmakers are interested in changing the law that prohibits non-group/individual health insurance from being sold across state lines. For example, Representative John Shadegg's (R-AZ) and Senator Jim DeMint's (R-SC) Health Care Choice Act (H.R. 2355 and S.1015) would amend current law to allow for interstate commerce in health insurance plans while preserving states' primary responsibility for the regulation of health insurance. Advocates of this reform argue that state-level mandates for providers, benefits, and coverage, as well as other types of regulations (e.g. guaranteed issue, community rating, and any willing provider status) distort prices and that permitting national competition for such insurance has the potential to increase demand for individual health insurance policies. The objective of this analysis is to simulate the difference between national and state-specific individual insurance markets on take-up of individual health insurance. Though the analysis focuses on the individual insurance market, results are presented for both the individual and group markets because the effects a national marketplace for insurance will also affect the small employer group market as well.

## Policy Analysis Objective

To simulate the difference between national and state-specific individual insurance markets on take-up of individual health insurance.

## Methods

This analysis was completed in three steps. First, an inventory of available literature was completed to identify parameters for the simulation. Second, we reviewed the literature and used empirical data to develop premium estimates for the simulation that reflect case-mix as well as state-specific differences. Third, we used a revised version of the 2005 Medical Expenditure Panel Survey (MEPS) to complete a set of simulations to identify the impact of three different scenarios for national market development. We briefly summarize these steps. A more detail description of our methods is provided in Appendix 1.

### *Characterize the state-specific individual insurance markets*

The first step in this simulation is to describe the regulatory environment of the individual insurance market in each state. We used several secondary sources for this description, including Blue Cross/Blue Shield for state mandates; the Georgetown University Health Policy Institute for guaranteed issue and community rating; and Thomson-West's Netscan/Health Policy Tracking Service ("Major Health Care Policies, 50 State Profiles, 2003/2004") for any willing provider laws.

The second step is to identify the marginal cost of particular regulations, including mandates, guaranteed issue, community rating, and any willing provider laws.

- Mandates are state regulations that require insurers to cover particular services or providers. We opted to use the count of mandates in a state rather than trying to identify the separate cost of each mandate. This decision follows the empirical work, which typically uses a count of state mandates.

- Guaranteed issue laws require insurers to sell insurance to all potential customers regardless of health or pre-existing conditions. However, this doesn't necessarily mean that insurers can't put riders on pre-existing conditions or incorporate premium adjustments for them. Guaranteed issue provisions can be broad (e.g. applying to all products, all consumers, at all times) or narrow (e.g. applying to very specific populations or during specific open enrollment periods). Our coding rules are biased toward those states that had fairly broad guaranteed issue provisions.

- Community rating requires insurers to limit premium differences across individuals. We coded a state as having community rating if it had 'pure' (no premium differences are allowed) or 'adjusted' community rating. We did not consider rating bands as part of this definition.

- Any willing provider (AWP) laws restrict insurers' ability to exclude providers from their networks. There is a lot of variability here as well. Many states apply AWP laws narrowly (e.g. to pharmacies only). We coded a state as having an AWP law if it applied broadly to providers.

We conducted a literature review to identify estimates of the impact of these state laws and regulations on health insurance premiums.[1] We used only studies of the individual insurance market, since this is the market in which we are interested. This ruled out using studies that focus on the relationship between regulations and premiums in the small-group market (e.g. Simon, 2005).

We utilized estimates from the following four studies: Congdon, et al. (2005); Henderson, et al. (2007); New (2006); and Hadley and Reschovsky (2003). It should be noted that only the Hadley and Reschovsky (2003) paper has been published in a peer-reviewed journal. The other three are working papers.[2] In Table 1, we summarize the key findings:

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[1] A copy of the literature review with complete references is attached as Appendix 2.

[2] Other studies, particularly from the Urban Institute, have examined the effects of mandates on insurance coverage. However, these studies did not have sufficient information to inform the modeling requirements of our analysis. In order to use them for our purposes, we would have needed to adjust them with estimates of the responsiveness of coverage to prices, i.e. dPrice/dRegulation = (dCoverage/dRegulation) / (dCoverage/dPrice). The addition of a second level of uncertainty into our simulations is the drawback of this two-step approach.

**Table 1**
**Summary of Studies of the Effects of Sate Regulations on Premiums in the Individual Health Insurance Market**

| Regulation/Law | Congdon, et al. | Henderson, et al. | New | Hadley & Reschovsky |
|---|---|---|---|---|
| Guaranteed Issue | 94-114% increase in premium in one state (NJ) | No effect | NA (not assessed) | No effect |
| Community Rating | 20-27% increase in premium | No effect | NA | 15-34.6% increase in premium |
| Any Willing Provider | 1.5-9% increase in premium | 5-12% increase | NA | NA |
| Mandates | Each additional mandate increases premium .4-.9%. | Used indicator variables for a very comprehensive set of mandates. Some increase and some decrease premium. | Each additional mandate raises the monthly premium by 75 cents, approximately .5%. | NA |

To make our analysis comprehensive, we used three summary measures of the regulatory effects: (1) the midpoint of the range[3] of the estimated effect of each regulation/mandate – our moderate estimate; (2) the minimum estimated effect; and (3) the maximum estimated effect. These effects are summarized in Table 2.

**Table 2**
**Minimum, Maximum, and Midpoint Estimates of the Effects of Regulations**

| Regulation | Minimum Increase | Midpoint Increase | Maximum Increase |
|---|---|---|---|
| Guaranteed Issue | 0 | 57% | 114% |
| Community Rating | 0 | 17.3% | 34.6% |
| Any Willing Provider | 1.5% | 6.75% | 12% |
| Mandates | .4% per mandate | .65% per mandate | .9% per mandate |

[3] The midpoint is simply the calculated mean between the minimum and maximum increase effects of the regulations.

Regulations and mandates represent important differences across state-specific individual insurance markets, but there may be other factors as well.

***Calculate simulation premiums***

The second step in the analysis requires calculation of premiums adjusted for the effects of state regulations. The basic idea behind a national market is that a person living in State A will be able to buy insurance licensed in State B. Suppose I live in State A where the premium is $100 per month. This reflects the influence of my state's medical practice style and provider prices (which would not change if I bought insurance in State B) and the effects of regulations (which would change). If I bought insurance in State B, the premium would be $100 minus the effects of fewer regulations in State B.

To implement this step, we relied on the premiums reported by Congdon, Kowalski, and Showalter (2005). These premiums were first adjusted by age and sex to reflect standard actuarial differences in health care costs, and then they were adjusted by the effects of regulations as summarized in Appendix 3. The adjusted premiums were used as inputs into the insurance take-up simulation model.

***Simulation***

In the third step we simulated the effect of a national market on take-up of individual health insurance. This step requires that we know the state of residence for people in the MEPS-Household Component, (MEPS-HC), but the MEPS will not release person-specific state IDs. Therefore, we had to devise a method for imputing each person's state of residence. This step is described in more detail in Appendix 1.

Application of State-Specific MEPS to National Simulation Model

Using a simulation model developed from previous analyses (Feldman, Parente, Abraham, et al., 2005; Parente, Feldman and Abraham, 2007), we applied the Synthetic State MEPS (SS-MEPS) described above and in Appendix 1 to develop a set of national estimates. The simulation model is capable of generating estimates of national health plan take-up for both the individual and employer-sponsored insurance (ESI) markets.

One of the distinguishing attributes of the simulation model is the presence of consumer driven health plans (CDHPs). Specifically, there are two types of CDHPs: a low-option Health Reimbursement Arrangement (HRA) and a high-option HRA. The low-option HRA is very similar in deductible, coinsurance and premium structure to a Health Savings Account (HSA) plan. This enabled us to model both HRA and HSA choices in the simulation as well as high, moderate and low-option Preferred Provider Organizations (PPOs), and a Health Maintenance Organization (HMO).

In the simulation, consumers in the individual market have five choices: high, moderate and low-option PPO, HSA, and the choice to be uninsured. Consumers with employer-sponsored coverage are given up to eight choices including HMO, three PPO options, an

HRA, an HSA where the employee opts out of employer sponsored coverage, an HSA where the employer picks up most of the cost of the HSA/high deductible insurance policy, and finally a choice to turn down coverage for any reason (e.g. already had coverage from spouse).

Chronic illness is modeled at the contract level in the simulations. That is, either the person choosing insurance, or someone covered by their insurance contract, has a chronic illness. This assumption was made because the data used to estimate the health plan choice model could only be attributed to contract holders, not the person receiving care under a contract. As a result, the chronic illness metric reflects a household's illness burden, more than that of one individual, unless the person is buying a single-coverage contract.

The simulation model adjusts premiums for the tax treatment of health insurance offered by employers in the ESI market. Specifically, premiums are adjusted to take into consideration the federal marginal tax rate as well as the social security tax burden. The capability to adjust for state tax effects is also possible, but not considered in this model in order to identify the pure effects of differences in insurance regulations by state.

We use premium estimates for each of the plan choices based on our earlier work (Feldman, Parente, Abraham, et al., 2005). These premium estimates are derived from a combination of ehealthinsurance.com and Kaiser/Commonwealth estimates of premium prices. These premium estimates are adjusted to 2008 dollars.

We develop state-specific premium inflators/deflators from the AHIP individual market single and family coverage report. Individual market premiums were experience rated for age and gender (with the exception of community rated states). For this analysis, we define the small group market as one where an employer has less than 250 employees. At this level, employers generally do not self-insure. Premiums for employers with less than 250 employees were adjusted by state-specific regulatory effects. Finally, HSA premiums include a $1,000/$2,000 investment in accounts depending upon whether the person was choosing a single or family insurance product, respectively.

The simulation is based only on choices made by adults aged 19-64 who are not students, not covered by public insurance, and not eligible for coverage under someone else's ESI policy. As a result, our baseline uninsured and turned down population represents 32.3 million people (we edited out military, students, age under 18 or 65 and older, and those without ESI offer who could be covered by spouse). However, we present results for our selected sample as well as a national approximation that would yield 47 million people uninsured.

Scenarios for Policy Simulation

We developed three different scenarios for policy simulation. Each of these simulations was run on a set of minimum, moderate and maximum impacts of state-specific regulations as derived from the literature. The impact of each scenario was calculated by

multiplying a given person's original premium by a state min/mod/max specific multiplier. These multipliers are described in Appendix 4 by state. For each scenario, if the consumer faces a lower premium as a result of the proposed policy change, the consumer will choose the better price. If the new possible premium is not a better deal than that in the consumer's home state, they will stick with their home state in the simulation. The three scenarios are:

*Scenario 1: Competition among 5 largest states*

In this scenario, only the five largest states are permitted to be available for the national market along with the consumer's own state. The rationale for this scenario was that it was considered in a previous legislative proposal. The idea is that large states would have the critical skills in their insurance departments to take on additional regulatory responsibilities for new out-of-state consumers. The five largest states in the United States, based upon population size, are (in order of descending population size): California, Texas, New York, Florida, and Illinois. Of these, Texas has the least regulated health insurance environment and is the comparison state in the simulations.

*Scenario 2: Competition among all 50 states*

For this scenario, the state with the least regulation is identified as Alabama. In this simulation, all consumers are assumed to find Alabama the state to which they would switch policies unless they were already residents of Alabama. This could be the most extreme outcome of legislation similar to that proposed by Rep. John Shadegg (R-AZ) for the last few years.

*Scenario 3: Competition within regions*

Under this scenario, the United States' health insurance market is divided into four regions: Northeast, South, Midwest, and West. Residents in each region buy insurance from a state within their region with the most favorable premium due to decreased regulation. This scenario was based on the regional Part D and TriCare contract models for insurance carriers. For the Northeast, the state with least-cost regulation impact was New Hampshire. In the Midwest, Nebraska was the favored state. In the West, the state of choice was Arizona and in the South, the state of choice was Alabama.

**Findings**

The findings from the simulations are presented below. First, results for each scenario are presented. Second, we describe the impact of the moderate estimates for the national scenario in breakdowns by income and state of residence.

***Impact by Insurance Scenario***

For each scenario, the change in the number of insured is presented from a 2008 status quo estimate. The insurance market is divided into the individual and group markets and further demarcated by the types of health insurance taken up from the simulation model. The HSA No-offer category in the group market refers to individuals who were offered coverage but turned it down and bought an HSA policy on their own. All of the detailed numbers are from the limited sample with national approximations provided for the aggregate impacts of each scenario. For each scenario, we provide a 'within' sample and national estimate. The within sample is based on the 18-64 aged sample from MEPS and the national estimate is an extrapolation to all non-Medicare aged US citizens.

The impact of competition among the five largest states is presented in Table 3. Under the minimum, moderate and maximum effects of state policies, there is improvement in the level of insurance. The impact ranges from 69,444 (minimum) to 11.6 million (maximum) newly insured from a base number of 47 million uninsured. The moderate impact is 7.5 million newly insured individuals. Most of that effect is observed in the individual market.

**Table 3**
**Scenario 1: Competition among 5 largest States**

| | | Scenario 1 | | | | | |
|---|---|---|---|---|---|---|---|
| | Status | Least Regulated Top 5 State - Texas | | | | | |
| | Quo | Mininum | | Moderate | | Maximum | |
| Individual | | | | | | | |
| HSA | 4,655,291 | 10,337 | 0% | 812,972 | 17% | 1,289,019 | 28% |
| PPO High | 7,515,552 | 27,115 | 0% | 2,479,808 | 33% | 4,450,141 | 59% |
| PPO Low | 180,379 | (267) | 0% | (22,772) | -13% | (30,916) | -17% |
| PPO Medium | 1,534,799 | 687 | 0% | 16,995 | 1% | 8,908 | 1% |
| Uninsured | 28,848,310 | (37,872) | 0% | (3,287,002) | -11% | (5,717,152) | -20% |
| Group Market | | | | | | | |
| HMO | 5,505,466 | (6,159) | 0% | (762,628) | -14% | (1,143,619) | -21% |
| HRA | 6,166,134 | (2,984) | 0% | (269,016) | -4% | (438,955) | -7% |
| HSA Offered | 307,298 | (482) | 0% | (56,901) | -19% | (77,608) | -25% |
| HSA No-offer | 11,088 | 48 | 0% | 10,485 | 95% | 25,041 | 226% |
| PPO High | 16,535,831 | 8,487 | 0% | 1,308,780 | 8% | 1,827,254 | 11% |
| PPO Low | 665,950 | (862) | 0% | (161,976) | -24% | (220,539) | -33% |
| PPO Medium | 53,470,814 | 12,840 | 0% | 1,926,239 | 4% | 2,434,256 | 5% |
| Turned Down | 3,530,681 | (10,888) | 0% | (1,994,983) | -57% | (2,405,829) | -68% |

| | Within Sample | National |
|---|---|---|
| Mininum Insurance Estimate: | 48,759 | 69,445 |
| Moderate Insurance Estimate: | 5,281,985 | 7,522,827 |
| Maximum Insurance Estimate: | 8,122,981 | 11,569,095 |

Allowing for a national market where anyone can shop for health insurance in any state yields the simulated results presented in Table 4. The reduction in the number of uninsured is greater than the first scenario across the minimum, moderate and maximum regulation effects. The moderate national impact is just over 12 million previously uninsured who now have coverage. As in the first scenario, the greatest improvement occurs in the individual market. The greatest take-up is for the high-option PPO, followed by the Health Savings Account. There is a net transfer out of low-option PPO plans toward high-option PPO plans. This finding makes sense in that if someone could afford a more generous plan design due to a lower premium they would make the switch. In the employer-sponsored market, there is movement out of the HMO in favor of medium-option PPOs. Once again, the medium-option PPO is more expensive than the HMO and also more favored than the HMO. As a result, if the price of health insurance is reduced, more will opt for the newly more affordable medium-option PPO.

**Table 4**
**Scenario 2: Competition among All States**

| | | Scenario 2 | | | | | |
|---|---|---|---|---|---|---|---|
| | Status | Least Regulated State - Alabama | | | | | |
| | Quo | Mininum | | Moderate | | Maximum | |
| Individual | | | | | | | |
| HSA | 4,655,291 | 345,512 | 7% | 1,390,604 | 30% | 1,690,744 | 36% |
| PPO High | 7,515,552 | 973,979 | 13% | 4,560,713 | 61% | 7,411,603 | 99% |
| PPO Low | 180,379 | (10,515) | -6% | (37,603) | -21% | (52,379) | -29% |
| PPO Medium | 1,534,799 | 36,214 | 2% | 42,742 | 3% | 28,632 | 2% |
| Uninsured | 28,848,310 | (1,345,190) | -5% | (5,956,457) | -21% | (9,078,600) | -31% |
| Group Market | | | | | | | |
| HMO | 5,505,466 | (220,241) | -4% | (1,114,650) | -20% | (1,529,468) | -28% |
| HRA | 6,166,134 | (96,537) | -2% | (454,184) | -7% | (660,064) | -11% |
| HSA Offered | 307,298 | (19,005) | -6% | (81,630) | -27% | (103,864) | -34% |
| HSA No-offer | 11,088 | 2,522 | 23% | 19,898 | 179% | 43,230 | 390% |
| PPO High | 16,535,831 | 376,588 | 2% | 1,792,964 | 11% | 2,343,582 | 14% |
| PPO Low | 665,950 | (42,910) | -6% | (214,315) | -32% | (272,079) | -41% |
| PPO Medium | 53,470,814 | 613,956 | 1% | 2,551,739 | 5% | 3,022,911 | 6% |
| Turned Down | 3,530,681 | (614,374) | -17% | (2,499,822) | -71% | (2,844,248) | -81% |

| | Within Sample | National |
|---|---|---|
| Mininum Insurance Estimate: | 1,959,564 | 2,790,894 |
| Moderate Insurance Estimate: | 8,456,279 | 12,043,791 |
| Maximum Insurance Estimate: | 11,922,847 | 16,981,025 |

Under the scenario of competition within four regions in the United States shown in Table 5, we find greater insurance coverage than the status quo, but less impact than a national market among all 50 states. Interestingly, coverage is higher under this scenario than under the 'five largest state' scenario. The moderate insurance estimate for this scenario indicates a net increase of just over 11 million newly insured. Movement across plans is fairly consistent with what was observed in previous tables and the greatest change occurs in the individual market. The minimum insurance estimate is

disproportionately smaller than the national market minimum estimate, suggesting that regional competition might expose greater sensitivity to expected differences in state mandates.

**Table 5**
**Scenario 3: Competition among States in 4 Regions**

| | | Scenario 3 | | | | | |
|---|---|---|---|---|---|---|---|
| | Status | Least Regulated State in 4 Regions - AL,AZ,NE,NH | | | | | |
| | Quo | Mininum | | Moderate | | Maximum | |
| Individual | | | | | | | |
| HSA | 4,655,291 | 273,357 | 6% | 1,230,693 | 26% | 1,557,056 | 33% |
| PPO High | 7,515,552 | 807,254 | 11% | 4,221,135 | 56% | 6,868,237 | 91% |
| PPO Low | 180,379 | (9,175) | -5% | (35,815) | -20% | (49,615) | -28% |
| PPO Medium | 1,534,799 | 33,600 | 2% | 37,436 | 2% | 22,584 | 1% |
| Uninsured | 28,848,310 | (1,105,036) | -4% | (5,453,448) | -19% | (8,398,262) | -29% |
| Group Market | | | | | | | |
| HMO | 5,505,466 | (140,557) | -3% | (994,350) | -18% | (1,408,263) | -26% |
| HRA | 6,166,134 | (75,582) | -1% | (406,888) | -7% | (605,391) | -10% |
| HSA Offered | 307,298 | (11,331) | -4% | (74,750) | -24% | (97,600) | -32% |
| HSA No-offer | 11,088 | 1,936 | 17% | 17,437 | 157% | 37,968 | 342% |
| PPO High | 16,535,831 | 196,143 | 1% | 1,624,974 | 10% | 2,182,670 | 13% |
| PPO Low | 665,950 | (20,858) | -3% | (194,308) | -29% | (255,140) | -38% |
| PPO Medium | 53,470,814 | 323,772 | 1% | 2,364,368 | 4% | 2,893,495 | 5% |
| Turned Down | 3,530,681 | (273,524) | -8% | (2,336,483) | -66% | (2,747,738) | -78% |

| | Within Sample | National |
|---|---|---|
| Mininum Insurance Estimate: | 1,378,559 | 1,963,403 |
| Moderate Insurance Estimate: | 7,789,931 | 11,094,751 |
| Maximum Insurance Estimate: | 11,146,000 | 15,874,606 |

***National Impact Scenario by Income and State***

Using the person specific estimates from the simulations, we generated an estimate of insurance take-up by those with annual wage income greater than $45,000 and those with less than $45,000 income. We chose to focus on the national competition scenario (#2) and used the moderate insurance estimate to identify the impact by different income levels. An income level of $45,000 was chosen to represent an estimated national mean household income. The income-specific results are shown in Table 6.

In the individual market, we find the greatest percentage increase in insurance occurring among the population with less than $45,000 income (44%), compared with those with more than $45,000 income (37%). Interestingly, we find a smaller percentage decrease in the uninsured among lower-income individuals (-19%) than higher-income individuals (-29%). This difference suggests that premium costs remain too high for lower-income individuals to take-up insurance even after the having the ability to shop in a less regulated state.

In the group market, the response is quite substantial and appears to reduce the number of people who turn down insurance by over two million. The impact is greatest for those with lower incomes in the group market.

In Table 6 we also show the impact of a combination of a national marketplace and the 2008 State of the Union (SOTU) health insurance proposals. Specifically, those buying a single coverage contract would get a $7,500 tax deduction and those buying a family contract would get a $15,000 tax deduction. For the individual market, the combination of these two policies is fairly substantial with a 70% reduction in the uninsured among those earning less than $45,000 a year. In the group market, nearly everyone opts to take health insurance.

**Table 6**
**Impact of National Market (Scenario 2) and 2008 State of the Union Proposal by Insurance Status and Income**

| | | Scenario 2 | | | |
|---|---|---|---|---|---|
| | Status | AL as default least regulated State | | | |
| | Quo | National | | National & SOTU 2008 | |
| Indiviudal | Sample | Sample | % Change | Sample | % Change |
| Uninsured < $45K Income | 25,299,301 | 20,379,943 | -19% | 7,644,207 | -70% |
| Uninsured >= $45K Income | 3,544,843 | 2,508,945 | -29% | 3,119 | -100% |
| Insured < $45K Income | 11,109,728 | 16,029,086 | 44% | 28,764,822 | 159% |
| Insured >= $45K Income | 2,780,459 | 3,816,358 | 37% | 6,322,184 | 127% |
| Group Market | | | | | |
| Uninsured < $45K Income | 3,084,578 | 990,974 | -68% | 18,911 | -99% |
| Uninsured >= $45K Income | 446,103 | 39,886 | -91% | 69 | -100% |
| Insured < $45K Income | 47,414,484 | 49,508,088 | 4% | 50,480,151 | 6% |
| Insured >= $45K Income | 35,248,098 | 35,654,315 | 1% | 35,694,133 | 1% |
| | | Within Sample | | National | |

Another perspective on the impact of a national insurance market is the effect on states. We expect states with the highest regulatory burden would have the greatest movement to a less regulated state. In Table 7, we show the range of increased insurance coverage from the state of origin in the status quo situation to a national marketplace scenario. Percent changes reflect the difference from the combined individual and group markets at status quo to a different scenario. Highly regulated states such as New Jersey, Massachusetts, and West Virginia have the greatest percent changes.

We also model the combined impact of a national marketplace and the 2008 SOTU proposal and find similar distributional patterns, but a clearly accelerated movement from states where the insured are domiciled. In New Jersey, the percent of individuals with insurance increases from 49% to 79% due to the addition of the SOTU proposal.

**Conclusion**

We find evidence of a significant opportunity to reduce the number of uninsured under a proposal to allow the purchase of health insurance across state lines. The best scenario to reduce the uninsured, numerically, is competition among all 50 states with one clear winner. This idea is not without precedent outside the health care industry, where Delaware has become the most favored state for incorporating a firm. The most pragmatic scenario, with a good impact, is one winner in each regional market. This is a compromise since the U.S. health insurance industry is only 'half-way' national (through large employer-sponsored national contracts with insurers with national provider panels) and this could provide a practical, more politically palatable approach. The 'five large state' policy scenario is the least effective policy for increasing the number of insured people. This is likely due to the fact that only one state of the five, Texas, had a combined regulatory burden that is greater than the $50^{th}$ percentile of all states.

Although we have modeled the person-level impact of a national market on coverage, we are unable to assess the impact of such a migration on provider access or quality of care. Nevertheless, a national market would lead to substantial additional health care access which should lead to health improvements among the vulnerable populations who currently find health insurance unaffordable. In addition, development of a national market requires no additional federal resources other than support for legislation to permit the development of such a change to the U.S. health insurance market.

**Table 7**
**Impact of National Market (Scenario 2) and**
**2008 State of the Union Proposal by State**

| | Status Quo | | National Market | | | National Market & SOTU 2008 | | |
|---|---|---|---|---|---|---|---|---|
| State | Individual | Group | Individual | Group | % Change | Individual | Group | % Change |
| AK | 25,037 | 254,263 | 28,179 | 256,505 | 2% | 88,637 | 268,156 | 28% |
| AL | 358,089 | 1,524,624 | 358,089 | 1,524,624 | 0% | 756,128 | 1,559,473 | 23% |
| AR | 468,958 | 906,086 | 486,742 | 906,535 | 1% | 591,815 | 907,849 | 9% |
| AZ | 458,356 | 2,000,931 | 473,107 | 2,002,528 | 1% | 960,364 | 2,024,929 | 21% |
| CA | 3,463,657 | 12,594,829 | 4,134,239 | 12,640,976 | 4% | 6,524,469 | 12,695,976 | 20% |
| CO | 345,832 | 1,719,774 | 397,590 | 1,728,751 | 3% | 795,157 | 1,750,327 | 23% |
| CT | 89,322 | 1,416,085 | 112,755 | 1,433,670 | 3% | 285,887 | 1,455,601 | 16% |
| DE | 75,208 | 353,904 | 92,063 | 354,008 | 4% | 102,992 | 354,096 | 7% |
| FL | 1,144,407 | 5,972,619 | 2,149,740 | 6,073,232 | 16% | 3,318,945 | 6,088,419 | 32% |
| GA | 532,298 | 3,415,490 | 705,663 | 3,449,363 | 5% | 1,459,406 | 3,505,182 | 26% |
| HI | 136,951 | 513,589 | 189,264 | 514,055 | 8% | 221,737 | 514,251 | 13% |
| IA | 192,956 | 1,202,769 | 319,789 | 1,210,057 | 10% | 457,787 | 1,211,651 | 20% |
| ID | 134,906 | 464,616 | 235,620 | 470,266 | 18% | 311,348 | 471,552 | 31% |
| IL | 405,168 | 5,251,628 | 468,404 | 5,280,963 | 2% | 1,547,788 | 5,369,952 | 22% |
| IN | 621,452 | 2,330,686 | 728,286 | 2,341,523 | 4% | 1,008,499 | 2,367,869 | 14% |
| KS | 121,745 | 1,136,929 | 135,052 | 1,139,573 | 1% | 323,920 | 1,150,314 | 17% |
| KY | 387,604 | 1,474,683 | 436,786 | 1,482,466 | 3% | 769,118 | 1,495,250 | 22% |
| LA | 255,053 | 1,561,763 | 308,748 | 1,576,169 | 4% | 715,461 | 1,613,713 | 28% |
| MA | 19,520 | 2,276,118 | 203,552 | 2,623,960 | 23% | 628,438 | 2,682,821 | 44% |
| MD | 191,638 | 2,080,518 | 489,813 | 2,189,508 | 18% | 929,713 | 2,207,719 | 38% |
| ME | 109,339 | 550,625 | 163,509 | 551,523 | 8% | 183,695 | 551,766 | 11% |
| MI | 562,786 | 4,232,660 | 914,700 | 4,260,918 | 8% | 1,418,993 | 4,266,494 | 19% |
| MN | 226,333 | 2,180,219 | 264,055 | 2,184,629 | 2% | 604,106 | 2,191,664 | 16% |
| MO | 328,293 | 2,307,270 | 386,947 | 2,319,775 | 3% | 836,461 | 2,348,159 | 21% |
| MS | 241,562 | 980,110 | 249,421 | 980,632 | 1% | 484,727 | 984,911 | 20% |
| MT | 66,775 | 307,598 | 76,746 | 309,421 | 3% | 167,966 | 316,351 | 29% |
| NC | 640,622 | 2,998,459 | 1,137,836 | 3,049,092 | 15% | 1,690,097 | 3,056,095 | 30% |
| ND | 34,150 | 253,861 | 36,004 | 254,513 | 1% | 86,926 | 259,888 | 20% |
| NE | 81,174 | 671,256 | 85,171 | 672,228 | 1% | 217,563 | 681,159 | 19% |
| NH | 36,502 | 555,705 | 44,107 | 560,381 | 2% | 113,391 | 572,337 | 16% |
| NJ | 20,328 | 2,393,267 | 143,123 | 3,442,574 | 49% | 651,233 | 3,666,466 | 79% |
| NM | 240,329 | 637,256 | 263,614 | 638,385 | 3% | 394,608 | 641,028 | 18% |
| NV | 168,948 | 814,555 | 203,814 | 819,872 | 4% | 416,470 | 827,414 | 26% |
| NY | 121,626 | 6,753,047 | 705,435 | 7,714,923 | 22% | 1,920,968 | 7,797,242 | 41% |
| OH | 576,945 | 4,579,871 | 1,061,894 | 4,625,875 | 10% | 1,746,612 | 4,634,302 | 24% |
| OK | 209,904 | 1,208,503 | 236,684 | 1,216,491 | 2% | 567,520 | 1,253,537 | 28% |
| OR | 252,405 | 1,218,744 | 612,317 | 1,232,839 | 25% | 759,688 | 1,234,526 | 36% |
| PA | 644,614 | 4,853,335 | 1,028,563 | 4,877,657 | 7% | 1,466,033 | 4,882,420 | 15% |
| RI | 90,392 | 434,862 | 120,847 | 435,204 | 6% | 137,875 | 435,350 | 9% |
| SC | 225,440 | 1,395,668 | 237,629 | 1,401,073 | 1% | 596,097 | 1,458,583 | 27% |
| SD | 29,777 | 271,233 | 33,408 | 273,789 | 2% | 88,288 | 283,719 | 24% |
| TN | 401,215 | 1,948,370 | 463,574 | 1,966,210 | 3% | 1,022,969 | 2,023,530 | 30% |
| TX | 1,398,432 | 8,361,776 | 1,745,464 | 8,466,829 | 5% | 3,672,305 | 8,648,112 | 26% |
| UT | 371,112 | 876,221 | 387,514 | 876,517 | 1% | 500,439 | 877,486 | 10% |
| VA | 537,878 | 2,688,648 | 1,109,836 | 2,740,657 | 19% | 1,547,058 | 2,747,230 | 33% |
| VT | 48,290 | 252,989 | 74,855 | 253,427 | 9% | 82,523 | 253,538 | 12% |
| WA | 555,371 | 2,288,192 | 1,002,288 | 2,364,037 | 18% | 1,298,386 | 2,377,834 | 29% |
| WI | 276,530 | 2,239,075 | 297,050 | 2,243,965 | 1% | 683,167 | 2,273,097 | 18% |
| WV | 96,768 | 578,129 | 216,111 | 598,887 | 21% | 366,364 | 602,540 | 44% |
| WY | 35,246 | 177,949 | 43,078 | 180,070 | 5% | 92,970 | 184,690 | 30% |

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**Appendix 1**

**Full Description of Simulation Methods**

This analysis was completed in three steps. First, an inventory of available literature was completed to identify parameters for the simulation. Second, we reviewed the literature and used empirical data to develop premium estimates for the simulation that reflect case-mix as well as state-specific differences. Third, we used a revised version of the 2005 Medical Expenditure Panel Survey (MEPS) to complete a set of simulations to identify the impact of three different scenarios for national market development.

***Characterize the state-specific individual insurance markets***

(a) The first step in this simulation is to describe the regulatory environment of the individual insurance market in each state. We used several secondary sources for this description, including Blue Cross/Blue Shield for state mandates; the Georgetown University Health Policy Institute for guaranteed issue and community rating; and Thomson-West's Netscan/Health Policy Tracking Service ("Major Health Care Policies, 50 State Profiles, 2003/2004") for any willing provider laws. We attempted to be as consistent as possible by using the same sources of regulatory information used in the empirical work from which we take our cost estimates. This was challenging because some of the studies failed to provide reference information. This information was coded into a spreadsheet for use in subsequent steps of the analysis and is presented as Appendix 3.

(b) The second step is to identify the marginal cost of particular regulations, including mandates, guaranteed issue, community rating, and any willing provider laws.

- Mandates are state regulations that require insurers to cover particular services or providers. We opted to use the count of mandates in a state rather than trying to identify the separate cost of each mandate. This decision follows the empirical work, which typically uses a count of state mandates.

- Guaranteed issue laws require insurers to sell insurance to all potential customers regardless of health or pre-existing conditions. However, this doesn't necessarily mean that insurers can't put riders on pre-existing conditions or incorporate premium adjustments for them. Guaranteed issue provisions can be broad (e.g. applying to all products, all consumers, at all times) or narrow (e.g. applying to very specific populations or during specific open enrollment periods). Our coding rules are biased towards those states that had fairly broad guaranteed issue provisions.

- Community rating requires insurers to limit premium differences across individuals. We coded a state as having community rating if it had 'pure' (no

premium differences are allowed) or 'adjusted' community rating. We did not consider rating bands as part of this definition.

- Any willing provider (AWP) laws restrict insurers' ability to exclude providers from their networks. There is a lot of variability here as well. Many states apply AWP laws narrowly (e.g. to pharmacies only). We coded a state as having an AWP law if it applied broadly to providers.

We conducted a literature review to identify estimates of the impact of these state laws and regulations on health insurance premiums.[4] We used only studies of the individual insurance market, since this is the market in which we are interested. This ruled out using studies that focus on the relationship between regulations and premiums in the small-group market (e.g. Simon, 2005).

States may adopt regulations for reasons that are also related to the effect of those regulations on premiums. For example, a state may be 'pro-regulation' in all areas and that pro-regulation sentiment may enhance the effects of the regulations. However, we could not find any study that controlled for states' strong preferences for regulation. This may be due to the fact that many regulations were adopted in the 1990s or before and there is no premium data that can be matched to 'before' and 'after' the regulations were implemented. Because none of the studies controlled for self-selection, the results must be interpreted with caution.

Two studies (LaPierre, et al., 2005; Hadley and Reschovsky, 2003) analyzed the regulation-premium relationship using data on individuals who held health insurance policies. People who hold insurance may have characteristics that differ from those who shopped and didn't buy. For example, those who hold insurance may be low-risk. If these characteristics are not observed or controlled by the researcher, his or her estimates of the effects of regulations on premiums held by the insured will be biased. We eliminated the LaPierre, et al. (2005) study because they did not attempt to control for this bias. We retained the estimates from Hadley and Reschovsky (2003) since they used a selection-correction approach to control for unmeasured personal attributes related to both insurance and premiums.

We utilized estimates from the following four studies: Congdon, et al. (2005); Henderson, et al. (2007); New (2006); and Hadley and Reschovsky (2003).[5] It should be noted that only the Hadley and Reschovsky (2003) paper has been published in a peer-reviewed journal. The other three are working papers. In Table A1, we summarize the key findings:

[4] A copy of the literature review with complete references is attached.

[5] Other studies, particularly from the Urban Institute, have examined the effects of mandates on insurance coverage. However, these studies did not have sufficient information to inform the modeling requirements of our analysis. In order to use them for our purposes, we would have needed to adjust them with estimates of the responsiveness of coverage to prices, i.e. dPrice/dRegulation = (dCoverage/dRegulation) / (dCoverage/dPrice). The addition of a second level of uncertainty into our simulations is the drawback of this two-step approach.

**Table A1**
**Summary of Studies of the Effects of Sate Regulations on Premiums in the Individual Health Insurance Market**

| Regulation/Law | Congdon, et al. | Henderson, et al. | New | Hadley & Reschovsky |
|---|---|---|---|---|
| Guaranteed Issue | 94-114% increase in premium in one state (NJ) | No effect | NA (not assessed) | No effect |
| Community Rating | 20-27% increase in premium | No effect | NA | 15-34.6% increase in premium |
| Any Willing Provider | 1.5-9% increase in premium | 5-12% increase | NA | NA |
| Mandates | Each additional mandate increases premium .4-.9%. | Used indicator variables for a very comprehensive set of mandates. Some increase and some decrease premium. | Each additional mandate raises the monthly premium by 75 cents, approximately .5%. | NA |

To make our analysis comprehensive, we used three summary measures of the regulatory effects: (1) the midpoint of the range of the estimated effect of each regulation/mandate – our moderate estimate; (2) the minimum estimated effect; and (3) the maximum estimated effect. These effects are summarized in Table A2.

**Table A2**
**Minimum, Maximum, and Midpoint Estimates of the Effects of Regulations**

| Regulation | Minimum Increase | Midpoint Increase | Maximum Increase |
|---|---|---|---|
| Guaranteed Issue | 0 | 57% | 114% |
| Community Rating | 0 | 17.3% | 34.6% |
| Any Willing Provider | 1.5% | 6.75% | 12% |
| Mandates | .4% per mandate | .65% per mandate | .9% per mandate |

Regulations and mandates represent important differences across state-specific individual insurance markets, but there may be other factors as well. Here are a few issues:

(a) Regulations regarding look-back periods and pre-existing conditions: A lot of variation exists across states with respect to mandates regarding coverage of pre-existing conditions. This will impact people with chronic/acute illnesses differently than those who are healthy, both in terms of coverage value, prices (potentially), and take-up. Although we have information on state regulations for look-back periods and pre-existing conditions, we know of no studies that model the effect of these regulations on premiums.

(b) Premium taxes: We have not attempted to determine the effects of premium taxes on premiums in the non-group market.

(c) Provider networks and provider prices: Premium variation may also reflect differences across states (and plans within states) regarding the size of the provider network and plan types. AWP laws may capture some of this variation, but the extent of provider market power and local variation in prices is also likely to drive premiums.

***Calculate simulation premiums***

The second step in the analysis requires calculation of premiums adjusted for the effects of state regulations. The basic idea behind a national market is that a person living in State A will be able to buy insurance licensed in State B. Suppose I live in State A where the premium is $100 per month. This reflects the influence of my state's medical practice style and provider prices (which would not change if I bought insurance in State B) and the effects of regulations (which would change). If I bought insurance in State B, the premium would be $100 minus the effects of fewer regulations in State B.

To implement this step, we relied on the premiums reported by Congdon, Kowalski, and Showalter (2005). These premiums were first adjusted by age and sex to reflect standard actuarial differences in health care costs, and then they were adjusted by the effects of regulations as summarized in Appendix 3. The adjusted premiums will be used as inputs into the insurance take-up simulation model.

***Simulation***

In the third step we simulate the effect of a national market on take-up of individual health insurance. This step requires that we know the state of residence for people in the MEPS-Household Component, (MEPS-HC), but the MEPS will not release person-specific state IDs. Therefore, we had to devise a method for imputing each person's state of residence.

State-Specific Imputation of MEPS

Below, we summarize the process of imputation which resulted in the creation of 51 synthetic state populations from the 2005 MEPS-HC.

(a) We used the 2005 American Community Survey (ACS) to define the strata that would be used to generate the sample.[6] The final strata include four variables: Age (18-34, 35-44, 45-54, and 55-64); Income (1 if household income is in the lowest quartile, 0 if not); Male (1 if male, 0 if not); White (1 if white, non-Hispanic, 0 if not). Creating all possible combinations resulted in 32 cells per state. The unit of analysis for data construction is the person, not the household. Using person weights in the ACS, we tabulated the population frequencies for each of these strata by state.

(b) We divided the 2005 MEPS into four regions – Northeast, Midwest, South, and West. The District of Columbia is in the South region. We selected only 18-64 year-olds to match the ACS selection criteria. The regional MEPS samples had the following sizes:

**Table A3 – 2005 Regional MEPS Sample Size by Region**

| Region | Sample Size |
|---|---|
| Northeast | 2,874 |
| Midwest | 3,734 |
| South | 7,520 |
| West | 5,132 |

Within each of these regions, the strata were defined. We then wrote a STATA computer program to draw a random sample with replacement of 1,000 (approximately, given rounding) observations from the region containing a particular state.[7] The frequency of observations by strata was matched to represent the population (e.g. if 10% of the state is age 18-34, low-income, male, and non-white, then 100 of the 1,000 observations would be drawn from MEPS individuals of this type). After all of the random samples were drawn, the data were appended to form a national data set.

(c) While we know that the state samples match the socio-demographic criteria with respect to the strata, additionally we wanted to check to see how our samples looked with respect to insurance holding. To do this, we computed state-specific estimates of uninsurance from the 2006 Current Population Survey (CPS). We

[6] We used the ACS because it gave us state-specific distributions that were required to create the synthetic state markets for the analysis.

[7] The sample size for Hawaii had to be reduced to 600 because the MEPS sample from the Western region of the United States did not have enough representation among certain strata to accommodate the socio-demographics of Hawaii. STATA does not allow one to draw a random sample from a stratum that is larger than the population, even with replacement.

compared the uninsurance estimates generated for our synthetic state populations with the CPS estimates. This comparison fares pretty well. There are only two notable issues: (1) we tend to underestimate the amount of uninsurance in synthetic Northeast states due to the small MEPS sample and the population heterogeneity in the Northeast; and (2) uninsurance was overestimated in Washington, DC, because the sample is drawn from the entire South region and there is no easy way to account for the concentration of federal government workers in DC.

(d) After completing this exercise, we merged several other variables into the file and selected the sample to mimic the one we have used previously in simulations. In particular, we deleted cases of adult dependents who did not have an ESI offer but had a spousal offer (n = 8,609), those who reported having public insurance at any point during round 1 of MEPS (n = 4,725), and full-time students (n = 892). Also, we constructed the number of plans offered to each person by using an ordered probit model to predict whether those with an offer of ESI were offered 1, 2, 3, or 4+ plans. We computed predicted probabilities for each category and identified the category with the maximum probability as the number of offered plans.

Application of State-Specific MEPS to National Simulation Model

Using a simulation model developed from previous analyses (Feldman, Parente, Abraham, et al, 2005; Parente, Feldman and Abraham, 2007), we applied the Synthetic State MEPS (SS-MEPS) described above to develop a set of national estimates. The simulation model is capable of generating estimates of national health plan take-up for both the individual and the ESI markets. The estimates are based on predictions from a set of parameter estimates from a conditional logistic regression model of health plan choice. The conditional logistic regression model requires information on wage income, single or family status, presence of chronic illness, age, gender, and health plan premiums. The data used to generate the parameter estimates come from an aggregate database of large employers' human resources and claims data from 2003.

One of the distinguishing attributes of the simulation model is the presence of consumer driven health plans (CDHPs). Specifically, there are two types of CDHPs: a low-option Health Reimbursement Arrangement (HRA) and a high-option HRA. The low-option HRA is very similar in deductible, coinsurance and premium structure to a Health Savings Account (HSA) plan. This enabled us to model both HRA and HSA choices in the simulation as well as high, moderate and low-option Preferred Provider Organizations (PPOs), and a Health Maintenance Organization (HMO).

In the simulation, consumers in the individual market have five choices: high, moderate and low-option PPO, HSA, and the choice to be uninsured. The uninsurance parameter is calibrated based on the national rate of the uninsured in the individual market by income quartiles as determined from the 2005 MEPS sample. Consumers with employer-sponsored coverage are given up to eight choices including HMO, three PPO options, an

HRA, an HSA where the employee opts out of employer sponsored coverage, an HSA where the employer picks up most of the cost of the HSA/high deductible insurance policy, and finally a choice to turn down coverage for any reason (e.g. already had coverage from spouse).

Chronic illness is modeled at the contract level in the simulations. That is, either the person choosing insurance, or someone covered by their insurance contract, has a chronic illness. This assumption was made because the data used to estimate the health plan choice model could only be attributed to contract holders, not the person receiving care under a contract. As a result, the chronic illness metric reflects a household's illness burden, more than that of one individual, unless the person is only buying a single-coverage contract.

The simulation model adjusts premiums for the tax treatment of health insurance offered by employers in the ESI market. Specifically, premiums are adjusted to take into consideration the federal marginal tax rate as well as the social security tax burden. The capability to adjust for state tax effects is also possible, but not considered in this model in order to identify the pure effects of differences in insurance regulation by state.

We use premium estimates for each of the plan choices based on our earlier work (Feldman, Parente, Abraham, et al., 2005). These premium estimates are derived from a combination of ehealthinsurance.com and Kaiser/Commonwealth estimates of premium prices. These premium estimates are adjusted to 2008 dollars.

We develop state-specific premium inflators/deflators from the AHIP individual market single and family coverage report. Individual market premiums were experience rated for age and gender (with the exception of community rated states). For this analysis, we define the small group market as one where an employer has less than 250 employees. At this level, employers generally do not self-insure. Premiums for employers with less than 250 employees were adjusted by state-specific regulatory effects. Finally, HSA premiums include a $1,000/$2,000 investment in accounts depending upon whether the person was choosing a single or family insurance product, respectively.

The simulation is based only on choices made by adults aged 19-64 who are not students, not covered by public insurance, and not eligible for coverage under someone else's ESI policy. As a result, our baseline uninsured and turned down population represents 32.3 million people (we edited out military, students, under age 18 or 65 and older, and those without ESI offer who could be covered by spouse). However, we present results for our selected sample as well as a national approximation that would yield 47 million people uninsured.

Scenarios for Policy Simulation

We developed three different scenarios for policy simulation. Each of these simulations was run on a set of minimum, moderate and maximum impacts of state-specific regulations as derived from the literature. The impact of each scenario was calculated by

multiplying a given person's original premium by a state min/mod/max specific multiplier. These multipliers are described in Appendix 4 by state. For each scenario, if the consumer faces a lower premium as a result of the proposed policy change, the consumer will choose the better price. If the new possible premium is not a better deal than that in the consumer's home state, they will stick with their home state in the simulation. The three scenarios are:

*Scenario 1: Competition among 5 largest states*

In this scenario, only the five largest states are permitted to be available for the national market along with the consumer's own state. The rationale for this scenario was that it was considered in a previous legislative proposal. The idea is that large states would have the critical skills in their insurance departments to take on additional regulatory responsibilities for new consumers from out-of-state. The five largest states in the United States, based for population size, are (in order of descending population size): California, Texas, New York, Florida, and Illinois. Of these, Texas has the least regulated health insurance environment and is the comparison state in the simulations.

*Scenario 2: Competition among all 50 states*

For this scenario, the state with the least regulation is identified as Alabama. In this simulation, all consumers are assumed to find AL the state to which they would switch policies unless they were already residents of Alabama. This could be the most extreme outcome of the legislation similar to that proposed by Rep. John Shadegg (R-AZ) for the last few years.

*Scenario 3: Competition within regions*

Under this scenario, the United States' health insurance market is broken into four regions: Northeast, South, Midwest, and West. Residents in each region buy insurance from a state within their region with the most favorable premium due to decreased regulation. This scenario was based on the regional Part D and TriCare contract models for insurance carriers. For the Northeast, the state with least-cost regulation impact was New Hampshire. In the Midwest, Nebraska was the favored state. In the West, the state of choice was Arizona and in the South, the state of choice was Alabama.

**Appendix 2**

**Literature Review for Effects of State Regulations on Health Insurance Premium in the Small Group and Non-Group Markets**

***Effects of "Second Generation" Small Group Health Insurance Market Reforms, 1993 to 1997***

Authors: Marquis & Long, 2001

Data: NEHIS 1993-1996 and 1997 RWJF EHIS.

This study compared small group premiums in nine states that adopted guaranteed issue and rating restrictions (prohibiting the use of health status for premium rating) between 1993-1997 with 11 states and DC where none of these regulations were adopted. Outcomes were measured by premiums that took into account different plan benefits, the variability of premiums among employers, and the change of premiums over time. Only estimates from a difference-in-differences (D-in-D) model are reported in this summary. Results showed mixed effects. Regulations had a statistically significant impact only in New York where premiums for family coverage were reduced and in Oregon, where premiums increased. Between 1996 and 1997, small firms in NY had significantly lower premiums by 12.3%, while other eight states did not show statistically significant differences.

***Who Gains and Who Loses with Community Rating for Small Business?***

Authors: Buchanan & Marquis, 1999

Data: A half-sample of the May 1993 CPS, selecting working heads of families employed in a small firm at the time of the survey. Workers in the surveyed families were grouped into artificial small firms (under 50 workers). A simulation model predicted annual premiums, which were slightly smaller than the observed values. Experience rating and community rating were compared, using the RAND Health Plan Choice and Health Expenditures Simulation model. Simulation results showed that around 60% of the firms faced higher community-rated premiums than experience-rated premiums, and around 50% of the firms faced community-rated premiums 20% higher than the other rating policy. Also, the median premium paid by firms under experience rating was $1,132 on average, which was 40% lower than the $1,946 paid under community rating.

***The Effect of State Regulations on Health Insurance Premiums: A Preliminary Analysis***

Author: M. J. New, 2005

Data: Health premiums data from eHealthInsurance.com

State regulations have positive effects on premiums. A 'Health Plan Liability' law increases monthly premiums by $26.72; 'Direct-Access-To-Specialists' increases monthly premiums by $310; and 'Provider Due Process' increases premiums by $22.49. Each additional mandated benefit (not distinguished by type of mandate) increases monthly premiums by $0.89. The control group is monthly premiums for policies in states without the presence of 26 mandated benefits and the insurance laws mentioned above.

***The Effect of State Regulations on Health Insurance Premiums: A Revised Analysis***

Author: M. J. New, 2006

A revised paper showed results similar to the previous one. Health plan liability laws increase monthly premiums by $21.84. Direct-Access-To-Specialists increase monthly premiums by $31.15. Provider due process laws increase premiums by $16.62. Each additional mandated benefit increases premiums by $0.75.

***Study of Costs of Certain Mandated Benefits in Insurance Policies 2001***

Author: Wisconsin Office of the Commissioner of Insurance, 2002

This report showed that the costs of five mandated benefits as a percentage of total benefits decreased slightly compared with an earlier report, from 6.49% in 1990 to 5.53% in 2001. However, no details were presented regarding data and methods; therefore, the results of this report cannot be assessed.

***Price Sensitivity of Demand for Nongroup Health Insurance***

Author: Congressional Budget Office, 2005

Data: SIPP 2001-2005

This study imputed premiums for single workers in the non-group insurance market. Without state rating restrictions, premiums are estimated based on an individual's self-

reported health status, taking into account three age rates. With state rating restrictions, rating bands were applied to health or age factors based on the unregulated premiums; an additional 30% was added to premiums in states with pure community rating; this addition was proportionally reduced for states with weaker restrictions. A price ceiling of 2.5-3 times the average premium was applied to states with high-risk pools. State premium rating restrictions would reduce the annual premium for people with Fair or Poor health status, from $4,109 to $3,500 (-15%). Rating restrictions would raise the premium for people with Good, Very Good or Excellent health status, from $1,781 to $2,453 (38%). But these are not empirical results – they were created by an actuarial model to estimate the effects of regulations on take-up rates. The control group was states without rating restrictions.

***Health and the Cost of Non-group Insurance***

Authors: Hadley & Reschovsky, 2003

Data: 1999-2001 Community Tracking Study-household surveys

Community rating versus no health rating would increase monthly premiums by 14% under OLS estimation or by 35% under selection-adjusted estimation. The control group is households in states without community rating.

***State Health Insurance Regulations and the Price of High-Deductible Policies***

Authors: Congdon, Kowalski, & Showalter, 2005

Data: eHealthInsurance & Golden Rule

This study examines the impact of four state regulations on the premiums for high-deductible family and individual health insurance policies. All regulations increase premiums. Each additional mandated benefit would raise individual premiums by 0.4% and family premiums by 0.5%, relative to states with 21 or fewer mandated benefits. Any willing provider (AWP) would increase individual premiums by 1.5%, though the effect was not statistically significant, and would raise family premiums by 5.3%. Community rating would increase individual premiums by 20.3% and family premiums by 27.3%. Guaranteed Issue would raise individual premiums by 114.5% and family premiums by 95%. The control group is states without AWP, community rating, and

guaranteed issue (New Jersey was the only state that implemented this regulation in the sample), and states with 21 or fewer mandates. A simulation study examined the effect of eliminating AWP, community rating, and guaranteed issue, and limiting mandated benefits to 10. The individual premium is expected to drop by 10.2%, on average, and the family premium is expected to drop by 12.1%.

***Community Rating and Sustainable Individual Health Insurance Markets in New Jersey***

Authors: Monheit, Cantor, Koller, & Fox, 2004

Data: March 1996 – December 2001 New Jersey IHCP plans enrollment data.

In 1993 New Jersey adopted regulations including pure community rating, guaranteed issue, and guaranteed renewal for individual health insurance plans. Premiums for all of the four investigated IHCP plans increased during the four years, some by more than 3.5 times their initial level. By 2000, IHCP premiums exceeded and rose faster than employer-coverage premiums. From 1996 to 2000, premiums of three IHCP indemnity plans increased by 111.9%, 154.7%, and 141.0% respectively, and premiums of the IHCP HMO plan increased 48.1%. The study used the initial level of premiums in 1996 to contrast to those in 2000.

***Estimating the Impact of State Health Insurance Mandates on Premium Costs in the Individual Market Using the Community Tracking Survey***

Authors: LaPierre, Conover, Henderson, & Taylor, 2005

Data: Community Tracking Survey 1997-2003

This study found mixed effects for the number of mandated benefits on insurance premiums for four insurance types: single-coverage indemnity plans, family indemnity plans, single HMO plans, and family HMO plans. The total number of mandated benefits did not significantly impact premiums, but mandate waivers in the individual market reduced the family-indemnity premium by 129%. When groups of one person are permitted in the small group market, the single-indemnity premium is reduced by 32%, and the family-indemnity premium is reduced by 27%. Pure community rating reduces HMO family premium by 103%. An additional provider mandate reduces the HMO

family premium by 18% and an additional coverage mandate increases it by 70%. The mandate waivers in the individual market reduced indemnity family premium by 129%. The control group is the premium without the presence of those state regulations.

***The Effect of State Community Rating Regulations on Premiums and Coverage in the Individual Health Insurance Market***

Authors: Herring & Pauly, 2006

Data: NHIS 1997-2004, Community Tracking Study Household Survey 1998-2001, and MEPS 1996-2003

'Regulated' states in this study include MA, ME, NH, NJ, NY and VT, which implemented both community rating and guaranteed issue laws. The 'unregulated' states had neither community rating nor guaranteed issue. The question of interest is whether community rating and guaranteed issue change the relationship between the log of condition-related expenses and premiums. In unregulated states, annual premiums increase as condition-related expenses increase. Analysis using NHIS data showed about a 10% positive effect of log condition-related expenses on premiums, and the results from CTS data showed about 7% positive effects. In regulated states, premiums increase by 6.9% as log condition-related expenses increase in the NHIS dataset, and by 2.3% in the CTS dataset. But the differences are not statistically significant. Thus, community rating and guaranteed issue did not have much affect on the relationship between premiums and condition-related expenses. The control group was states with neither community rating nor guaranteed issue.

***State-Mandated Benefits and Employer-Provided Health Insurance***

Author: Gruber, 1994

Data: May CPS supplements for 1979, 1983, and 1988

This study investigated the effects of five expensive mandated benefits (mandated minimum benefits for alcoholism treatment, drug abuse treatment, and mental illness; mandated coverage for chiropractic services; and mandated continuation of coverage) on the propensity of small firms (less than 100 employees) to offer insurance. The author found that adding these five benefits to a health plan could increase premiums for the

average firm by 5%, but mandated benefits did not affect small firms' decisions to offer insurance. The control group is premiums in states without the presence of mandated benefits.

***Adverse Selection in Health Insurance Markets? Evidence from State Small-Group Health Insurance Reforms***

Author: Simon, 2005

Data: 1996 Medical Expenditure Panel Survey Insurance Component; 1993 NEHIS

Employer-level statistical analysis compared changes in premiums for small firms before and after 'full' reforms (both guaranteed issue and rating restrictions) to the changes for firms in non-reform states. Results showed that premiums increased on average by $7.80 a month per person after the implementation of rating restrictions and guaranteed issue laws.

**Appendix 3 – State Level Variation in Regulatory Impact**

| | Average State Premium | | State/National Premium Ratio | | State Regulation Presence (0/1) | | | |
|---|---|---|---|---|---|---|---|---|
| STATE | Single 2008 | Family 2008 | Single | Family | Community Rating | Any Willing Provider | Guaranteed Issue | Number of Mandates |
| AK | $3,435 | $5,821 | 1.371 | 1.253 | 0 | 0 | 0 | 25 |
| AL | $2,548 | $4,545 | 1.017 | 0.978 | 0 | 0 | 0 | 15 |
| AR | $1,440 | $1,953 | 0.575 | 0.420 | 0 | 0 | 0 | 29 |
| AZ | $2,440 | $3,984 | 0.974 | 0.857 | 0 | 0 | 0 | 18 |
| CA | $1,885 | $3,972 | 0.752 | 0.855 | 0 | 0 | 0 | 40 |
| CO | $2,198 | $4,216 | 0.877 | 0.907 | 0 | 0 | 0 | 31 |
| CT | $2,963 | $5,660 | 1.183 | 1.218 | 0 | 0 | 0 | 37 |
| DE | $1,220 | $2,026 | 0.487 | 0.436 | 0 | 0 | 1 | 16 |
| FL | $2,539 | $4,882 | 1.013 | 1.051 | 0 | 0 | 1 | 38 |
| GA | $2,910 | $4,956 | 1.161 | 1.067 | 0 | 1 | 0 | 27 |
| HI | $1,455 | $2,678 | 0.581 | 0.576 | 0 | 0 | 1 | 18 |
| IA | $1,965 | $3,753 | 0.784 | 0.808 | 0 | 0 | 1 | 15 |
| ID | $2,207 | $3,788 | 0.881 | 0.815 | 0 | 1 | 1 | 6 |
| IL | $2,591 | $4,991 | 1.034 | 1.074 | 0 | 0 | 0 | 27 |
| IN | $2,330 | $2,505 | 0.930 | 0.539 | 0 | 1 | 0 | 24 |
| KS | $2,260 | $4,510 | 0.902 | 0.971 | 0 | 0 | 0 | 25 |
| KY | $2,033 | $4,442 | 0.811 | 0.956 | 0 | 1 | 0 | 23 |
| LA | $2,858 | $4,874 | 1.141 | 1.049 | 0 | 0 | 0 | 31 |
| MA | $5,257 | $10,126 | 2.098 | 2.179 | 1 | 0 | 1 | 33 |
| MD | $3,279 | $6,574 | 1.309 | 1.415 | 0 | 0 | 1 | 46 |
| ME | $1,455 | $2,678 | 0.581 | 0.576 | 1 | 0 | 1 | 33 |
| MI | $1,926 | $3,968 | 0.769 | 0.854 | 0 | 0 | 1 | 19 |
| MN | $2,121 | $4,141 | 0.847 | 0.891 | 0 | 0 | 0 | 34 |
| MO | $2,299 | $3,985 | 0.918 | 0.858 | 0 | 0 | 0 | 31 |
| MS | $1,205 | $4,721 | 0.481 | 1.016 | 0 | 0 | 0 | 20 |
| MT | $2,418 | $4,350 | 0.965 | 0.936 | 0 | 0 | 0 | 27 |
| NC | $2,623 | $4,467 | 1.047 | 0.961 | 0 | 0 | 1 | 34 |
| ND | $2,420 | $4,072 | 0.966 | 0.876 | 0 | 0 | 0 | 20 |
| NE | $2,295 | $4,119 | 0.916 | 0.887 | 0 | 0 | 0 | 19 |
| NH | $3,134 | $5,382 | 1.251 | 1.158 | 0 | 0 | 0 | 30 |
| NJ | $6,048 | $14,403 | 2.414 | 3.100 | 1 | 0 | 1 | 30 |
| NM | $1,982 | $2,985 | 0.791 | 0.642 | 0 | 0 | 0 | 29 |
| NV | $2,364 | $5,096 | 0.944 | 1.097 | 0 | 0 | 0 | 38 |
| NY | $3,743 | $9,696 | 1.494 | 2.087 | 1 | 0 | 1 | 34 |
| OH | $2,304 | $4,541 | 0.920 | 0.977 | 0 | 0 | 1 | 19 |
| OK | $3,047 | $4,813 | 1.216 | 1.036 | 0 | 0 | 0 | 26 |
| OR | $2,162 | $3,971 | 0.863 | 0.855 | 1 | 0 | 1 | 21 |
| PA | $1,989 | $3,916 | 0.794 | 0.843 | 0 | 0 | 1 | 25 |
| RI | $1,298 | $2,584 | 0.518 | 0.556 | 0 | 0 | 1 | 29 |
| SC | $3,328 | $5,230 | 1.328 | 1.126 | 0 | 0 | 0 | 20 |
| SD | $3,133 | $5,228 | 1.250 | 1.125 | 0 | 0 | 0 | 26 |
| TN | $2,851 | $5,047 | 1.138 | 1.086 | 0 | 0 | 0 | 29 |
| TX | $2,836 | $4,940 | 1.132 | 1.063 | 0 | 0 | 0 | 38 |
| UT | $1,308 | $2,530 | 0.522 | 0.545 | 0 | 0 | 0 | 28 |
| VA | $2,332 | $4,631 | 0.931 | 0.997 | 0 | 0 | 1 | 39 |
| VT | $1,455 | $2,678 | 0.581 | 0.576 | 1 | 0 | 1 | 14 |
| WA | $3,141 | $3,342 | 1.254 | 0.719 | 1 | 0 | 1 | 29 |
| WI | $2,373 | $4,462 | 0.947 | 0.960 | 0 | 0 | 0 | 21 |
| WV | $3,141 | $5,338 | 1.254 | 1.149 | 0 | 0 | 1 | 28 |
| WY | $2,734 | $4,734 | 1.091 | 1.019 | 0 | 1 | 0 | 25 |
| USA | $2,506 | $4,646 | 1.000 | 1.000 | | | | |

## Appendix 4 State-specific Premiums and Scenario Adjustors

| STATE | S_PREM | F_PREM | S_FLATE | F_FLATE | REG | MIN | MOD | MAX | SCEN1 | SCEN2 | SCEN3 | SCEN1_P | SCEN2_P | SCEN3_P |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| AK | 1529 | 2683 | 1.051066 | 1.001716 | S | 1.10 | 1.16 | 1.23 | TX | AL | AL | 1.247 | 1.0975 | 1.0975 |
| AL | 1645 | 3447 | 1.130806 | 1.28696 | S | 1.06 | 1.10 | 1.14 | TX | AL | AL | 1.247 | 1.0975 | 1.0975 |
| AR | 1440 | 1953 | 0.989885 | 0.729165 | W | 1.12 | 1.19 | 1.26 | TX | AL | AZ | 1.247 | 1.0975 | 1.117 |
| AZ | 1570 | 2178 | 1.07925 | 0.813171 | W | 1.07 | 1.12 | 1.16 | TX | AL | AZ | 1.247 | 1.0975 | 1.117 |
| CA | 1640 | 2799 | 1.127369 | 1.045025 | W | 1.16 | 1.26 | 1.36 | TX | AL | AZ | 1.247 | 1.0975 | 1.117 |
| CO | 1311 | 2811 | 0.901208 | 1.049505 | W | 1.12 | 1.20 | 1.28 | TX | AL | AZ | 1.247 | 1.0975 | 1.117 |
| CT | 2084 | 3739 | 1.432584 | 1.39598 | NE | 1.15 | 1.24 | 1.33 | TX | AL | NH | 1.247 | 1.0975 | 1.195 |
| DE | 1220 | 2026 | 0.838653 | 0.75642 | NE | 1.06 | 1.67 | 2.28 | TX | AL | NH | 1.247 | 1.0975 | 1.195 |
| FL | 1551 | 2879 | 1.066189 | 1.074894 | S | 1.15 | 1.82 | 2.48 | TX | AL | AL | 1.247 | 1.0975 | 1.0975 |
| GA | 1674 | 3679 | 1.150741 | 1.373579 | S | 1.12 | 1.24 | 1.36 | TX | AL | AL | 1.247 | 1.0975 | 1.0975 |
| HI | 1454.71 | 2678.405 | 1 | 1 | W | 1.07 | 1.69 | 2.30 | TX | AL | AZ | 1.247 | 1.0975 | 1.117 |
| IA | 1123 | 1386 | 0.771973 | 0.517472 | MW | 1.06 | 1.67 | 2.28 | TX | AL | NE | 1.247 | 1.0975 | 1.1235 |
| ID | 1572 | 3248 | 1.080625 | 1.212662 | W | 1.04 | 1.68 | 2.31 | TX | AL | AZ | 1.247 | 1.0975 | 1.117 |
| IL | 1657 | 2670 | 1.139055 | 0.996862 | MW | 1.11 | 1.18 | 1.24 | TX | AL | NE | 1.247 | 1.0975 | 1.1235 |
| IN | 1296 | 2505 | 0.890897 | 0.935258 | MW | 1.11 | 1.22 | 1.34 | TX | AL | NE | 1.247 | 1.0975 | 1.1235 |
| KS | 1333 | 3413 | 0.916331 | 1.274266 | MW | 1.10 | 1.16 | 1.23 | TX | AL | NE | 1.247 | 1.0975 | 1.1235 |
| KY | 1304 | 2456 | 0.896396 | 0.916964 | S | 1.11 | 1.22 | 1.33 | TX | AL | AL | 1.247 | 1.0975 | 1.0975 |
| LA | 1372 | 2826 | 0.943141 | 1.055106 | S | 1.12 | 1.20 | 1.28 | TX | AL | AL | 1.247 | 1.0975 | 1.0975 |
| MA | 1454.71 | 2678.405 | 1.3 | 1.3 | NE | 1.13 | 1.96 | 2.78 | TX | AL | NH | 1.247 | 1.0975 | 1.195 |
| MD | 1231 | 2100 | 0.846214 | 0.784049 | NE | 1.18 | 1.87 | 2.55 | TX | AL | NH | 1.247 | 1.0975 | 1.195 |
| ME | 1454.71 | 2678.405 | 1.1 | 1.1 | NE | 1.13 | 1.96 | 2.78 | TX | AL | NH | 1.247 | 1.0975 | 1.195 |
| MI | 1140 | 1957 | 0.783659 | 0.730659 | MW | 1.08 | 1.69 | 2.31 | TX | AL | NE | 1.247 | 1.0975 | 1.1235 |
| MN | 1546 | 2828 | 1.062752 | 1.055852 | MW | 1.14 | 1.22 | 1.31 | TX | AL | NE | 1.247 | 1.0975 | 1.1235 |
| MO | 1339 | 2607 | 0.920456 | 0.973341 | MW | 1.12 | 1.20 | 1.28 | TX | AL | NE | 1.247 | 1.0975 | 1.1235 |
| MS | 1205 | 2009 | 0.828341 | 0.750073 | S | 1.08 | 1.13 | 1.18 | TX | AL | AL | 1.247 | 1.0975 | 1.0975 |
| MT | 1361 | 2016 | 0.935579 | 0.752687 | W | 1.11 | 1.18 | 1.24 | TX | AL | AZ | 1.247 | 1.0975 | 1.117 |
| NC | 1237 | 2607 | 0.850339 | 0.973341 | S | 1.14 | 1.79 | 2.45 | TX | AL | AL | 1.247 | 1.0975 | 1.0975 |
| ND | 1454.71 | 2678.405 | 0.9 | 0.9 | MW | 1.08 | 1.13 | 1.18 | TX | AL | NE | 1.247 | 1.0975 | 1.1235 |
| NE | 1357 | 2500 | 0.932829 | 0.933391 | MW | 1.08 | 1.12 | 1.17 | TX | AL | NE | 1.247 | 1.0975 | 1.1235 |
| NH | 1454.71 | 2678.405 | 1.1 | 1.1 | NE | 1.12 | 1.20 | 1.27 | TX | AL | NH | 1.247 | 1.0975 | 1.195 |
| NJ | 2732 | 6004 | 1.878032 | 2.241633 | NE | 1.12 | 1.94 | 2.76 | TX | AL | NH | 1.247 | 1.0975 | 1.195 |
| NM | 1202 | 2204 | 0.826279 | 0.822878 | W | 1.12 | 1.19 | 1.26 | TX | AL | AZ | 1.247 | 1.0975 | 1.117 |
| NV | 1930 | 3654 | 1.326721 | 1.364245 | W | 1.15 | 1.25 | 1.34 | TX | AL | AZ | 1.247 | 1.0975 | 1.117 |
| NY | 1454.71 | 2678.405 | 1.9 | 1.9 | NE | 1.14 | 1.96 | 2.79 | TX | AL | NH | 1.247 | 1.0975 | 1.195 |
| OH | 1342 | 2424 | 0.922518 | 0.905016 | MW | 1.08 | 1.69 | 2.31 | TX | AL | NE | 1.247 | 1.0975 | 1.1235 |
| OK | 1476 | 2296 | 1.014632 | 0.857227 | S | 1.10 | 1.17 | 1.23 | TX | AL | AL | 1.247 | 1.0975 | 1.0975 |
| OR | 1493 | 2435 | 1.026318 | 0.909123 | W | 1.08 | 1.88 | 2.68 | TX | AL | AZ | 1.247 | 1.0975 | 1.117 |
| PA | 1251 | 2055 | 0.859963 | 0.767248 | NE | 1.10 | 1.73 | 2.37 | TX | AL | NH | 1.247 | 1.0975 | 1.195 |
| RI | 1298 | 2584 | 0.892271 | 0.964753 | NE | 1.12 | 1.76 | 2.40 | TX | AL | NH | 1.247 | 1.0975 | 1.195 |
| SC | 1576 | 2804 | 1.083374 | 1.046892 | S | 1.08 | 1.13 | 1.18 | TX | AL | AL | 1.247 | 1.0975 | 1.0975 |
| SD | 1135 | 2727 | 0.780222 | 1.018143 | MW | 1.10 | 1.17 | 1.23 | TX | AL | NE | 1.247 | 1.0975 | 1.1235 |
| TN | 1362 | 2602 | 0.936266 | 0.971474 | S | 1.12 | 1.19 | 1.26 | TX | AL | AL | 1.247 | 1.0975 | 1.0975 |
| TX | 1531 | 2891 | 1.05244 | 1.079374 | S | 1.15 | 1.25 | 1.34 | TX | AL | AL | 1.247 | 1.0975 | 1.0975 |
| UT | 1308 | 2530 | 0.899146 | 0.944592 | W | 1.11 | 1.18 | 1.25 | TX | AL | AZ | 1.247 | 1.0975 | 1.117 |
| VA | 1572 | 2619 | 1.080625 | 0.977821 | S | 1.16 | 1.82 | 2.49 | TX | AL | AL | 1.247 | 1.0975 | 1.0975 |
| VT | 1454.71 | 2678.405 | 1 | 1 | NE | 1.06 | 1.83 | 2.61 | TX | AL | NH | 1.247 | 1.0975 | 1.195 |
| WA | 1634 | 3342 | 1.123245 | 1.247758 | W | 1.12 | 1.93 | 2.75 | TX | AL | AZ | 1.247 | 1.0975 | 1.117 |
| WI | 1334 | 1860 | 0.917019 | 0.694443 | MW | 1.08 | 1.14 | 1.19 | TX | AL | NE | 1.247 | 1.0975 | 1.1235 |
| WV | 1454.71 | 2678.405 | 0.9 | 0.9 | S | 1.11 | 1.75 | 2.39 | TX | AL | AL | 1.247 | 1.0975 | 1.0975 |
| WY | 1185 | 2140 | 0.814593 | 0.798983 | W | 1.12 | 1.23 | 1.35 | TX | AL | AZ | 1.247 | 1.0975 | 1.117 |

Key:

| | |
|---|---|
| STATE | State of Insured |
| S_PREM | Single premium aggregate base |
| F_PREM | Family premium aggregate base |
| S_FLATE | State-specific single premium supply cost adjustment |
| F_FLATE | State-specific family premium supply cost adjustment |
| REG | Region mapping |
| MIN | Minimum state-specific effect of regulation |
| MOD | Moderate state-specific effect of regulation |
| MAX | Maximum state-specific effect of regulation |
| SCENX | X denotes scenario, State mapped for residents under scenario |
| SCENX_P | X denotes scenario, Scenario & state specific new regulation adjustor |

Mr. PALLONE. Thank you.
Mr. Holland.

**STATEMENT OF E.J. HOLLAND, JR., SENIOR VICE PRESIDENT, HUMAN RESOURCES AND COMMUNICATION, EMBARQ**

Mr. HOLLAND. Thank you, Mr. Chairman, Ranking Member Deal. My name is E.J. Holland, Jr., although most people call me Ned. I am senior vice president of human resources and communications at Embarq in Overland Park, Kansas. We are the fourth largest telecommunications company in this country, I think AT&T, Verizon, Qwest, and then Embarq. We are fourth. We are usually before the members of this committee on other issues. We are pleased to be here today with respect to healthcare issues, about which we feel strongly and about which I personally have a strong interest.

I want to thank the chairman particularly and the members of his able staff for the personal courtesy they have shown me as I have come here today. I couldn't have felt more welcome and I appreciate it.

I have been working on these issues, Mr. Chairman, for the better part of 40 years. That may mean I should get out of it and perhaps they could be solved. I am not sure I have had that much impact. I particularly appreciate today that you have included an employer on the panel. All too often in these kinds of events, I see academics and healthcare people and theorists and not people who actually write some 60 percent of the checks that are written to pay for this system in the country. But while I am an employer, I also want to observe that I have spent better than 30 years on the board and served as chairman of the public hospital system in Kansas City, Missouri, Truman Medical Center, so I come with a view towards covering the indigent and the uninsured, and I currently serve on the board of the Kansas Health Policy Authority, where we are responsible for all healthcare purchasing in the State of Kansas, all Medicaid and all state employee healthcare purchasing, an innovative approach that Kansas has taken out in the plains.

I have a fairly diverse background, therefore, and I come at this issue with my conflicts in my mind but I am persuaded that reform of the healthcare system is of critical importance to my shareholders, my employees, my company, and indeed to the United States. It has become a burden on a number of industries. It causes chaos in industries. I think of steel and I think of the auto companies. It is well on its way to causing chaos in the telecommunications industry.

From my perspective as an employer, I can tell you that the current system harms American business as it struggles to stay competitive with the rest of the world and it harms those of us who do the right thing already as we struggle to remain competitive with people who don't do the right thing even here in the United States. So on two counts, we are behind the eight ball, if you will. The problem is far larger and more complex than we can solve at Embarq or that employers and employer groups I belong to can solve. We need the help of several States. I would join Governor Corzine's suggestion that the States can be creative in laboratories.

I agree with that. I would observe that and urge you not to villainize employers. It is we who provide a great deal of the healthcare in the country. We are there as an accident of history. Wage and price controls in the 1940s and World War II are what caused employers to be where we are today, but we are where we are and we try to deal with it on a daily basis.

I will tell you that we have every bell and whistle you can think of in our healthcare plans. We do all the right things with respect to wellness and preventive care and the like and still I am facing a $20 million deficit this year. That may seem like much in the federal budget but it is a lot in my budget and I am responsible for trying to cure it.

We believe that cost is critical. Keeping the employers in the system and assuming that we can just pick up cost increases year after year just won't work. No other part of my budget went up this year. No other part of my budget will go up next year. That is true of my colleagues. And we hear the stories that Chairman Dingell, I believe, talked about, how much healthcare the auto companies pay as compared to how much steel they buy or how much coffee Starbucks buys as compared to how much healthcare it buys. Well, we are well on our way in my company. My CFO observed to me the other day that if I don't stop—he looks to me to do it—the escalation of healthcare costs, we will be spending more on healthcare than we do on information technology, and as you know in our industry, information technology is the core of what we do. It can't be that way.

I have listed in my prepared testimony that has been submitted already, Mr. Chairman, four areas in which I would urge the committee to pay some attention. One, we need to invest in information technology for healthcare. We need to arrest the growth in other parts of the system and we do invest in things that are productive of better diagnostics and better record keeping. The notion of individual electronic medical record is long since overdue. If we did technology at Embarq like the healthcare system is doing, then I am afraid, I don't mean to be disrespectful, but we would be giving you tin cans strung together with twine to do your communications. We just can't continue to function in this fashion.

Second, we really believe we need national quality standards, and I have heard several people talk about that, and I won't repeat that. It is a crime that we have different standards in northern Maine and southern California, different standards for minorities and majorities, different standards for men and women. That can't continue.

We believe we should create better physician reimbursement systems. I won't burden you with that. It is in my written testimony.

And finally, we do think overall what is critical is to expand the participation pool. Everyone must be in the system. That is the way ultimately to level the costs and to share the costs of the social contract, the fabric of that social contract in the country. And to do that will take standards at the federal level. We would like to be able to experiment in Kansas along with Massachusetts and New Jersey.

Mr. PALLONE. I have to tell you, you are a minute over.

Mr. HOLLAND. And I will stop, Mr. Chairman. Thank you for your courtesy. We appreciate your attention to this issue. It is critical for us and you know it is critical for the country.

[The prepared statement of Mr. Holland follows:]

SUMMARY OF TESTIMONY

I am E. J. Holland, Jr., Senior Vice President of Human Resources and Communications at Embarq Corporation, with headquarters in Overland Park, Kansas. As an employer representative, I am absolutely persuaded that reform of the health care system is critical for my company, its shareholders, and its employees and, in fact, our country as a whole. **The burden of providing health care coverage has created a tremendous competitive disadvantage to American employers**. It has caused chaos in several industries and is well on its way to creating similar chaos in my own: telecommunications.

My perspective has been shaped by a diverse professional background, including 24 years as an attorney representing physicians and health care organizations and 16 years in Fortune 500 companies responsible for health care purchasing. There are many viewpoints on this complex problem, and my background helps me consider more than one; but **from my perspective as an employer, I can tell you that the current system harms American business as it struggles to stay competitive with the rest of the world.** It is enormously wasteful in a time when wastefulness can kill an economy. Many of the system's processes, practices and business models are inexcusably archaic when compared to the state-of-the-art medicine it is intended to deliver.

**The problems are far larger and more complex than anything employers and employees can solve.** Over the years, while I have been on both sides of the issue, a substantial percentage of the creative things I have seen done to try to contain costs have been done by major employers, like General Electric, IBM, the auto companies and others. I like to think that my last three employers have been in those ranks. The fact is, employers can implement all the program and cost-control measures known to man and still end up facing the $20M deficit we are facing at Embarq this year.

It is non-productive to argue for blowing the system up and starting over. **Taking an evolutionary approach to reform, there are a few incremental things we can do now to move the system forward, such as:**

- **Invest in our information technology infrastructure for health care**
- **Establish national quality standards for health care**
- **Create appropriate physician reimbursement incentives**
- **Expand the participation pool as much as possible even while allowing for policy experimentation at various levels.**

I believe we can put the U.S. health care system on the path toward the purpose for which it originally was conceived. The need for health care reform in this country is real, and it is urgent.

TESTIMONY OF E.J. (NED) HOLLAND, JR.

SENIOR VICE PRESIDENT OF HUMAN RESOURCES AND COMMUNICATIONS,

EMBARQ CORPORATION, OVERLAND PARK, KANSAS

BEFORE THE UNITED STATES HOUSE OF REPRESENTATIVES

COMMITTEE ON ENERGY AND COMMERCE SUBCOMMITTEE ON HEALTH

THE HONORABLE JOHN DINGELL, COMMITTEE CHAIR

THE HONORABLE JOE BARTON, RANKING COMMITTEE MEMBER

THE HONORABLE FRANK PALLONE, JR., SUBCOMMITTEE CHAIR

THE HONORABLE NATHAN DEAL, RANKING SUBCOMMITTE MEMBER

Mr. Chairman and distinguished committee members:

I am E. J. Holland Jr., Senior Vice President of Human Resources and Communications at Embarq Corporation, with headquarters in Overland Park, Kansas. Before I begin, I should make clear that, while I am responsible for health care purchasing at Embarq, my testimony here is provided on my own behalf and does not necessarily reflect the views of Embarq, its shareholders, its board members, its management, or of any of the health care organizations on whose boards I sit.

It is my privilege to testify before this distinguished committee of the United States House of Representatives on what I believe to be the most pressing economic issue of our time. I believe I was invited here today because I am an employer representative

who favors reform of the health care system and let me be clear about that. I am absolutely persuaded that reform of the health care system is critical for my company, its shareholders and its employees and, in fact, our country as a whole. The burden of providing health care coverage has created a tremendous competitive disadvantage to American employers. It has caused chaos in several industries — steel and automobiles come to mind — and it is well on its way to causing similar chaos in other industries, including my own: telecommunications.

My perspective has been shaped by a rather diverse professional background, about which I will share more in a moment. In my comparatively broad view, there is no silver bullet that will put an end to this country's health care system nightmare. I believe that successfully reforming the system will not come in the form of a revolution but rather through a deliberate series of evolutionary steps, and I believe that among those key steps should be:

- Invest in our information technology infrastructure for health care.
- Establish national quality standards for health care.
- Adopt appropriate physician reimbursement incentives.
- Expand the participation pool as much as possible while allowing for policy experimentation at various levels.

In the testimony that follows, I will expand on each of these opportunities, share with you some examples of how health care continues to create business challenges at my company and what we're doing to address them, and I will offer my views of the health care system overall. But first, I should tell you something about the professional background that has shaped my perspective on the subject.

**My background**

I am a graduate of Rockhurst College in Kansas City, Missouri, and of Boston College Law School in Boston, Massachusetts. I practiced law for 24 years with a firm that represented physicians and health care organizations. During that time, I provided services to the Kansas City Area Hospital Association, The Missouri Hospital Association, The American Hospital Association, and dozens of individual hospitals. In addition, I served on two separate hospital boards, chaired one of them; and chaired the Kansas City Area Hospital Association, the hospital industry association in the greater Kansas City area. Sixteen years ago I left the practice of law and took a position in a Fortune 500 company. Since that time I have been responsible for health care purchasing, among other things, at three successive Fortune 500 companies.

I was said to have "changed sides," but the truth is, there really are no sides on this issue. Since becoming a purchaser, I have served on a variety of boards, including the National Business Group on Health and the Mid-American Coalition on Health Care and I have been involved actively in Better Health Care Together and Care Focused Purchasing, which I helped to found.

Currently, I serve on the board of Joint Commission Resources, a subsidiary board of the Joint Commission on Accreditation of Health Care Organizations in Chicago. This subsidiary operates Joint Commission International, providing accreditation and other services to hospitals throughout the world. I also serve on the board of the Kansas Health Policy Authority, an independent board charged with setting health policy and overseeing all health care purchasing in the state of Kansas, roughly $2.5 billion a year. I chair that organization's Finance and Audit Committee and have

chaired its CEO Search Committee. Finally, like most of us will be sooner or later, I have been a patient in our health care system.

Sometimes I think this varied background constitutes a series of conflicts of interest. On the other hand, I hope it gives me a broad and somewhat sympathetic view of the various interests that inevitably arise as we discuss how to resolve the health care emergency in this country. I was appointed to the Kansas Health Policy Authority and recently reappointed by the very able Republican President of the Kansas Senate, Senator Steve Morris. When he approached me about serving, we discussed the sometimes partisan nature of the health care debate, but Senator Morris observed that health care is not a partisan issue. I completely share his views on that and have worked both with him and our Democratic Governor, Kathleen Sebelius. At the same time, I reminded Senator Morris that I had served many years as an active advocate for the hospital industry. He suggested that that would give me a useful insight into several sides of the issue. I continue to serve at Senator Morris' request, and I treasure the opportunity to have worked with him as we try to address some of these issues, at least in Kansas.

**How health care continues to create business challenges at my company**

The health care purchasing in which I have been involved most recently has been for a combination of Sprint and Embarq, which is a Sprint spin-off. With Sprint we purchased health care for up to 80,000 employees and at Embarq we have purchased for up to 20,000 employees. You need to multiply those numbers by a relativity factor between 2.25 or 2.5 to determine how many employees, spouses and dependents we actually served, which is somewhere around 200,000 at Sprint and somewhere around 50,000 at Embarq. At Sprint we purchased in 50 states and at Embarq we purchase in 39

states. Both provide multiple plan choices for employees, with up to five in any given market. Both have a variety of plans ranging from indemnity plans through PPOs, EPPs, High Performing Networks, and Commercial HMOs. At Sprint and Embarq, we require our employees to participate in our health care plan or provide evidence that they are covered by another employer-sponsored group health plan. We simply believe that everyone should have coverage.

I invest my time advocating for health care reform for many reasons, perhaps most immediately because it is critical for the health of my company. As employers fight the never-ending battle for improved productivity needed to compete in an international economy, we also are working to meet budget targets that routinely are down year-over-year. The one aspect of our budgets that has been totally uncontrollable in recent years has been health care. To use my own company for a current example, we are in an increasingly competitive, almost cut-throat, business. The days when the local phone company was a monopoly and earned a regular and guaranteed rate of return are long passed. My budget this year is lower than my budget last year, and my tentative budget for next year is lower than my budget this year. However, we have had an incredibly difficult time with health care this year. At the end of the first quarter, our health care purchasing trend rate was at approximately 20 percent, causing a budget deficit in excess of $20 million. For us that is an incredible problem, and I am in charge of solving it.

We are a fairly sophisticated purchaser, and we have lots of data at our finger tips. We know, for example, that there are two primary causes for the looming deficit for the year. The first is that our employees are visiting health care professionals far more often than in the past and, in our case, more often than the norm. The second is that

health care professionals are ordering more tests and procedures for our employees than they have done in the past, or than are the norm. Ironically, at the very same time, we know that the acuity of illness among our employees and their families is down markedly. Thus, our healthier employees are using services more frequently and are incurring higher costs. I have some theories as to why that might be the case, but they are no more than theories, and I will not burden the committee with them. The point is that the expense increase simply is unsustainable, and I am unable to explain it to my CEO or my CFO. Thus, in the coming year, we will have to find ways to rectify the financial situation. To do that, we will be required to increase premiums, increase co-pays, increase deductibles and increase out-of-pocket maximums for my employees. Once again health care costs for the company and our employees will rise faster than wages or general inflation. There are a few things that we will be able to do to attempt to decrease costs, such as negotiate more aggressive discounts with the providers; but overall, the adjustments primarily will be felt in cost shifting to employees of whom, of course, I am one.

**What we are doing to try to combat the health care problem at EMBARQ**

Having anticipated this problem, we have been taking advantage of our technological capabilities to engage in a dialogue with our employees on health care issues. I personally have a health care blog that I update regularly and respond to employee questions and comments. It is far and away the most active blog we operate on our company intranet. I have received literally hundreds of employee comments with ideas, complaints and occasional simple grousing. I don't dismiss any of it, even the grousing, because I know just how frustrating this problem is. Unfortunately, I have yet

to receive an idea from an employee that we have not already considered, but I keep hoping for some mystical magic bullet.

I find it distressing that, with increasing frequency, employees suggest to me that we should charge more to people who use the system than to people who do not and we should charge yet more, the more they use it. My concern is that this points to a hole in the fabric of the social contract — one that easily could lead to a rending of the contract altogether. To be sure, responses from some colleagues indicate their understanding that the health care plan is intended to spread risk and protect each of us when we have a particular problem. However, many comments I receive are that people who are overweight or who smoke or who have an unhealthy lifestyle — or who simply are sick — should pay more. Obviously, if we took that to its logical conclusion, we simply would give people the money to buy their own health care without any sort of intervention. As I see it, the problem is that without some sort of systemwide reform, an every-man-for-himself inclination will prevail and leave us in a situation that is even more dysfunctional than the one we are in today. In fact, as a practical matter, the cost shifting in which employers increasingly are forced to engage, is just another form of moving the costs shared by any common group — whether a company, the community or the nation — onto individual users. In the end, I really don't think that is in the nation's interest.

I assure you, we have been very creative and aggressive health care purchasers. We self-insure 95 percent of our plans (with very few isolated commercial HMOs available to some of our employees). We design our own benefits structure, eliminating such things as bariatric surgery, fertility treatments, non-sedating antihistamines, over-

the-counter drugs and various elective pharmaceuticals, as well the usual cosmetic surgery and the like. For several years while I was at Sprint we bought direct in Kansas City. That is, we purchased directly from doctors and hospitals and effectively created our own network of providers without an insurance company intermediary. During that period of time, when we were large enough to do it, we actually bought health care services 11 percent more efficiently in Kansas City than we did anywhere else in the country, simply because we cut out the middle man in the system.

At a previous employer, we instituted an in-house claims payment system, directly paying our providers and cutting out yet another intermediary in the process and saving large sums of money. Frankly, neither of those efforts is rocket science, but they require a sufficient number of covered lives to justify the investment.

We have carved out pharmaceuticals to purchase more effectively, collaborated with other employers to engage in that activity, designed alternative plans to attempt to provide appropriate incentives to employees, installed a wellness and disease management program — essentially all the bells and whistles you hear about. Still we are facing a 20 percent trend rate in 2008.

At Sprint, we even installed an on-site clinic which was very successful, but still it served only half the population eligible to use it. In fact, therein lies one of our problems; people frequently don't use what we provide them. For example, we provide non-smoker premium reductions, but not everybody who we are certain would be eligible for them takes advantage of them. We provide nurse advocate lines to assist employees in addressing this complex system, but less than 6 percent of our employees utilize them. We provide a health risk assessment with incentives to participate, but only 14 percent of

our employees utilize it. We provide complex case management, not to try to keep employees from getting health care, but to help them get the correct care. But again, we have one tenth of 1 percent usage. Frankly, we are beginning to look at replacing the various carrots with sticks of different sorts. Perhaps we will penalize people who don't take the health assessment. Perhaps we will double the deductibles for those who decline to participate in disease management. We are not yet sure, but those are the sorts of things at which we are looking.

Wellness programs clearly are the right thing to do. We installed one at Sprint, and we have one at Embarq. No responsible person would suggest that these are not a good idea. They are something like motherhood and apple pie. But, frankly, they produce marginal economic results that wouldn't convince a chief financial officer and simply are not the silver bullet to health reform in this country. Certainly, they satisfy the admonition attributed to Hippocrates, "First, do no harm," but they will not solve our problems. The calculation of the return on the investment in these programs makes calculus look like child's play. Our own projection is about $8 million savings over three years, but that is only about 1.3 percent of our cost each year and it is up against next year's projected trend of greater than 15 percent. These programs do no harm but will do only modest good. A real challenge with these programs is that, for any individual employer, it is difficult, perhaps impossible, to demonstrate that the investment is helping the employer and its shareholders. The problem is that, if I help an employee to be healthier, it may not serve our shareholders today but instead serve the shareholders of a company down the road, when the person leaves for a different job. The only real way to bring the value of broad-based wellness programs to the system is to install them on a

much wider community basis, an example of why the participation pool in general needs to be broadened.

One other thing to say about these wellness programs is that we actually receive complaints from employees when we aggressively promote the effort. Employees prefer to be left alone and they do not want to hear from some "insurance company." They wish to hear from their own physician. In fact, I have been working for several years on a project with the California Health Care Foundation investigating how to communicate with employees about evidence-based benefits and medicine. One of the clear things we have learned from that project is that employees do not wish to hear from their employers or their unions about health care. They wish to hear primarily from their own physicians, and that is understandable; and for employers to engage in the presumptuous theory that we can educate employees about how to behave in the health care system is questionable at best.

We have used health reimbursement accounts, but again, participation has been relatively limited; approximately 19 percent of the eligible employees participate. We have not used so-called consumer-directed health care plans or health savings accounts, although we have studied them carefully and we have watched their development. But frankly, we see them primarily as another means of cost shifting to employees and primarily as useful for the young, the healthy or the rich. From what I can tell by talking to my colleagues around the country, they work well only as a full replacement for all other health insurance alternatives, and our employees are accustomed to having choices in their health care plans. Frankly, we know how to drive employees from one plan

design to another. They will seek the lowest premium in droves every time and ignore the back end cost risks.

Again, employers can implement all the program and cost-control measures known to man and still end up facing the kind of deficit we are at Embarq this year. To sum it up: The problems are far larger and more complex than anything employers and employees can solve.

**My views of the health care system overall**

Let me turn for a few moments to the health care system itself. One thing I want to say about the interests involved in health care is that there really are no villains. Far too often, I hear employers somehow being cast as the villains. Without lecturing this distinguished panel, I do want to remind us all that employers' participation in health care in this country is an historical accident born of wage price controls during World War II. Most other countries have no such phenomenon. Over the years, while I have been on both sides of the issue, a substantial percentage, clearly a majority, of the creative things that I have seen done to try to contain costs have been done by major employers like General Electric, IBM, the auto companies and others. I like to think that my last three employers have been in those ranks.

I am fully aware that, when I offer a critique of the system, I am critiquing some of my own work and advocacy over almost a quarter of a century. Perhaps there is truth to that old saying that we get too soon old and too late smart. In any event, in the business world, when we engage in a new project, one of the very first things asked of us is to "benchmark," that is to study what others have done with respect to the issue at hand. Benchmarking our health care system against the rest of the world, as my father would

have said, is a "non-habit-forming activity." We spend more — more per capita, more as a percentage of the gross domestic product — than any other country, but our results demonstrably are among the worst among the western industrial democracies. To be sure, in this country, you can get the most sophisticated treatment for the most esoteric disease, and we can increase your odds of surviving something that you would not survive anyplace else in the world. The question we must ask ourselves is whether those individual outcomes can justify our societal investment. If we did a business case using the facts the health care system presents, no business I know would undertake the project.

There are some common fallacies that I would like to point out. One is that competition somehow will solve all our problems. I wish you could come with me to our corporate headquarters at the corner of Nall Avenue and Interstate 435 in Overland Park, Kansas. I can look out my 10th floor window and see half a dozen physician-owned or physician joint-ventured, stand-alone medical facilities. For some reason, which is not clear to me (perhaps simply our lack of certificate of need legislation), Kansas is one of the hotbeds of this sort of activity. The Kansas Health Policy Authority recently commissioned a study on the free-standing, largely physician-owned clinics. The facts are fairly clear. Competition has not driven down costs; it has driven them up. More to the point, the availability of these clinics inevitably causes increased usage. This industry is a classic example of "build it and they will come." It is the only industry I know of in which the laws of supply and demand are turned upside down. In health care, unlike what we were taught in Econ 101, supply drives demand rather than vice versa. Even worse, to whatever extent these facilities are successful, they take the highest-margin work from our community hospitals which, ultimately, most of us will need. The result is that the

community hospitals must increase their unit charges and in the end, we pay twice. When we were building our own provider networks and purchasing directly in the Kansas City area, we simply excluded these facilities from participation in our plans.

Nor is this a problem of cuts and scrapes or kids' visits to ERs (although ER visits by the uninsured are a problem). Like most of the systems, some 15 percent of our employees consume 85 percent to 90 percent of our health care dollars. Unfortunately, however, the 15 percent changes every year. Nearly three quarters of the expenses we incur are caused by chronic illness. In fact, we have about 10 percent of our population that does not have any medical spend year after year. We believe that if we are to solve this problem, we must have far more fundamental reform.

**Reforming the system through evolutionary steps**

I would like to talk about a few things I think we can do to move the system forward and I think it is non-productive to argue for blowing the system up and starting over. There simply are too many people and groups with vested economic interests. My friend, Dr. James Mongan, with whom many of you are familiar, likes to say that Americans are "raging incrementalists." Pardon the oxymoron but what he means simply is that we won't tolerate radical reform all at one time. I accept that as a given. We urgently do need, as I stated previously, at least four important things:

- Invest in our information technology infrastructure for health care.
- Establish national quality standards for health care.
- Adopt appropriate physician reimbursement incentives.
- Expand the participation pool as much as possible while allowing for policy experimentation at various levels.

Let me take those one at a time.

**Investment in our IT infrastructure for health care**

I have never seen an industry that has so resisted implementation of electronic systems. One hospital CEO actually told me a couple of years ago that they could not install a computerized physician order entry system because the doctors wouldn't learn the pass codes to get into the system. I told him he should get other doctors. We simply don't ask our staff whether they will learn their pass codes to get into our systems and no one could work for us without being technologically savvy. The variations and practice patterns, variations in diagnosis, and variations in treatment plans simply are irrational and unacceptable. We need the decision support tools developed on the basis of national standards. If we did telecommunications technology the way the health care industry has done its technology, we would be providing you tin cans with twine strung between them.

However, we should not put more money into the already bloated system. That means no new hospitals or and no new doctors' buildings. There is enough waste in the system to fund anything we need, including the complete digitization of the health care system, an improvement that could save billions more, and one on which we should insist. I am impatient with providers who acknowledge this need but want someone else to fund it. This afternoon I will get on a plane and return to Kansas City but I won't be paying extra for a plane that is equipped so it won't crash.

**Establishment of national quality standards for health care**

With respect to quality standards, I probably should not belabor things that are well known. Since the famous report from the Institute on Medicine, people have paid continuing attention to it and I actually think we are making some progress. Simply put

we should not pay for medical errors including so called "never events" and we need to agree upon ways to pay for quality more effectively.

Likewise, we should ban the age-old "Community Practice" language from our lexicon. That is a relic of medical malpractice litigation, and it gets us caught up in an assumption that things are different in the far northeast than in the far southwest. In fact, open-heart surgery should not be done differently in Bangor, Maine, than it is in San Diego, California. It should not be done differently for the minority population than it is done for the majority population. It should not be done differently for men and women (except, of course, to the extent that actual biological differences prevail).

I believe that physicians should develop recognized standards, and they should do it now. I was in a meeting a couple of years ago at the Institute of Medicine during which I witnessed a learned debate about the difference between a registry and a double-blind study and how it would take 10 years to complete a certain analysis. Quite Frankly, I told the very able people who deal with this academic issue that we can't wait 10 years because those of us who pay for health care all will be broke in the meantime. That is true of much of what we do here. While many of the wonders we accomplish through our health care system are a result of rigorous academic discipline, the problems we face need to be resolved more quickly than normal academic discipline would call for. This is not about the Nobel Prize; this is about bankruptcy. Several years ago I was with my own personal physician, receiving a check up, and I attempted to have a conversation with him about designing our network and what we are required to pay. He told me that he didn't want to be involved; he "hates HMOs" and he advised me to talk to his business people. I told him that was fine, but that if he did not want to be involved in making the decisions,

people like me would make them. I don't think that is the optimal answer, but if others decline the responsibility, they cannot be surprised when those of us who pay for the results choose to make decisions. By the way, not long after that conversation, we did revise our network and I needed to find a new primary care physician myself.

**Revised appropriate physician reimbursement incentives**

With respect to reimbursement incentives, I have some quite specific suggestions for you. We need physician reimbursement reform. The so called RBRVS "Resource Based Relative Value Scale" is outdated and inappropriate. Essentially, we pay the mechanics rather than paying the designers. If I paid my engineers less than I pay my field technicians I would be out of business. But we insist upon paying procedural practitioners more than we pay cognitive practitioners, that is those who design the care we provide to our patients. We also should be paying physicians in ways that will encourage efficient practice. For a small example, when I call my lawyer or send an e-mail, I begin paying her when she picks up the phone or when she opens my e-mail. I have no objection to that. However, many of our reimbursement systems refuse to pay physicians for similar activity. I am fortunate to have a personal physician who knows me well and who will engage me on that basis but he really doesn't get paid for it, and I think that is unfair. We also have to increase coordination of care substantially between and among the multitude of professionals who take care of us in any given incident of illness. Meanwhile, we need to squeeze practice pattern differences out of the system. Look no further than the groundbreaking Dartmouth work to see this problem in detail. I am not talking about "cookbook medicine" as some in organized medicine call it; I am talking

about the kind of decision support and consistency that all other professional disciplines seek and utilize.

Finally, I believe strongly that we need to arrest the growth in the system, particularly those specialty hospitals about which I spoke earlier. The way to find a hospital in the Kansas City metropolitan area is to look for the construction crane. Each not-for-profit hospital board believes it has the manifest destiny to provide for the health of the entire community. Unfortunately, none of them really can do that without coordinating what they do and build, and they end up duplicating facilities and providing their staff incentives to fill or otherwise utilize those facilities. We indeed need to put a stop to that.

**Expansion of the participation pool and experiment**

I hear from far too many people, including our employees that we should narrow risk pools, let people get "skin in the game," be personally responsible, and take care of themselves. I am persuaded that simply won't work and the extent to which we already have done it by creating around 46 million uninsured people helps demonstrate that it won't work.

During our work on health reform at the Kansas Health Policy Authority, we did a very detailed analysis of different sorts of reform initiatives. A couple of significant foundations paid for the services of an actuarial firm, Schramm-Raleigh of Phoenix, which did detailed projections. Among the things we asked them to do was to assess what we called "the mountain." In effect, we asked the consultants to price what it would cost Kansas to insure all its citizens, if we did it the way Embarq or Sprint or Boeing does — with a self-insured and self-administered plan that simply would provide care for

everyone who lived in the state. All of the other alternatives which we studied were calculated to decrease the future cost increases modestly. Only "the mountain" actually generated an overall decrease in projected costs, reducing roughly $800 million a year on an $8 billion base. Now this was not so much about who runs the system or how they run it, but rather about who is in it. While we did not seriously advocate this approach to the Kansas State Legislature, I think it is worth noting that the economics of the matter were quite compelling.

Frankly, I have no need to advocate a specific design alternative. We could have a federal answer; we could have a state answer; we could have regional purchasing cooperatives; and we even could have a robust individual market. Any of those is acceptable to me as long as it results in improving the care we deliver my employees and discontinuing the excess costs. It is my view that we must get everyone into the system, because, although I do not particularly like the insurance model as an intellectual way to approach the system, to the extent we use it, we must get everyone in the risk pool in order to be able to take advantage of both ends of the risk bell curve.

As we work to expand participation, we ought to encourage experimentation, until we come up with national standards and expectations. While I don't believe multiple state solutions will solve the problem, I do believe that our federal system was designed to permit, perhaps even encourage, states to serve as public policy laboratories to develop solutions to what may be national problems. Unfortunately, that has not worked well in the health care arena because of the impact of the Employee Retirement Income Security Act (ERISA). Now make no mistake, this was important and thoughtful legislation. It is ERISA that permits my company to provide nationally structured and funded benefits to

employees in 39 states, and I in no way wish to mitigate that salutary effect. However, I believe that we could construct a system for exemptions or "waivers" just like what has been done under the Medicaid program to permit state-level experimentation. Waivers could and should be constructed to allow multi-state employers to continue to provide benefits nationally. We are being responsible and we should not be penalized for that.

At the same time, ERISA has been used to dampen and interfere with all sorts of other less salutary activities. I am not talking about punitive state activity aimed at a single employer like we saw in Maryland. I don't believe that is productive activity. However, I have watched with interest as a variety of states, including my own, have addressed health reform alternatives and underlying every one of those health reform debates is the thread or the threat of ERISA. I simply think we are being short sighted if we resist all such experimental efforts. Carefully constructed waivers could protect what was intended to be protected by ERISA and still allow states to experiment in productive ways. While I believe strongly in adopting national standards and consistent national solutions, I believe that responsible state experimentation lead by groups like Robert Wood Johnson's State Coverage Institute can make a difference and might actually develop an ultimate national solution. With all due respect to the federal government, it actually could benefit from state-based or local experimentation. Massachusetts, San Francisco, even little Kansas might have things to teach us.

In the end, again, although I have views, it makes no difference to me what system is chosen. I have lived with different ones. However, unless we have fundamental reform, we are going to continue to drive employers out of the business of providing their employees with health care. We already have discontinued providing our retirees who are

over the age of 65 with health care support. They were not all happy about that, but we believe that the availability of Medicare plans allows them reasonable access to alternative coverage, and therefore, have reserved our retiree coverage to those under 65. Ultimately, if we don't have fundamental reform, employers will continue to send jobs overseas; they will move divisions overseas; they will do more business overseas — all of which will reduce the number of good jobs for Americans — while performing our fiduciary duty to protect our shareholders from irrational costs.

**In conclusion**

I am grateful to this distinguished committee for the opportunity to represent an employer's perspective on the need to reform the health care system in this country. The need is real and it is urgent. The current system impairs American business as it struggles to stay competitive with the rest of the world. It is enormously wasteful in a time when wastefulness can kill an economy. Many of the system's processes, practices and business models are inexcusably archaic when compared to the state-of-the-art medicine it is intended to deliver. If we can:

- Invest in our information technology infrastructure for health care
- Establish national quality standards for health care
- Adopt appropriate physician reimbursement incentives
- And expand the participation pool as much as possible while allowing for policy experimentation at various levels,

Then I believe we can put the U.S. health care system on an evolutionary path toward the noble purpose for which it originally was conceived. Thank you very much. I will be pleased to answer any questions the committee may have.

Mr. PALLONE. Thank you so much. I really appreciate your input on the employer's situation particularly.

Ms. Owen.

**STATEMENT OF PATRICIA OWEN, PRESIDENT AND FOUNDATION, FACES DAYSPA, THE VILLAGE AT WEXFORD**

Ms. OWEN. Thank you, Chairman Pallone and Ranking Member Deal, members of the committee. My name is Patricia Owen. I am the owner of FACES DaySpa, a 23-employee small business specializing in professional spa services located in Hilton Head Island, South Carolina. I am also here on behalf of the U.S. Chamber of Commerce and serve as a member of its council on small business. I commend the committee for its interest in having this hearing.

As owner of FACES DaySpa since its inception of 1983, I have guided my company from a small boutique to its current status as a nationally renowned, award-winning business. Back when my husband and I decided to move to Hilton Head Island, we used our hard-earned savings to open FACES boutique. What began as a small mom-and-pop business has now become one of the most extensive day spas in the Southeast. As owner of FACES, one of my most important duties is to attract and keep highly qualified employees. I find healthcare coverage is the most sought-after benefit that an employer can offer. Even so, in this salon and spa industry, it is rare that employers offer any form of healthcare options.

So almost 5 years ago, I took the plunge with a traditional PPO healthcare coverage plan that I made available to full-time employees working 40 hours a week. My company picked up $200 a month of the cost of the premium and my employees were responsible for the balance. However, this first plan was not well received by the employees. Premiums of older workers were more expensive than those of the younger ones, causing them not to participate, and the younger workers felt they had little incentive to participate in the plan. As a result, out of my 23 employees, only six took advantage of the benefit. Also, like most small business owners, I was faced with the challenge of soaring annual increases along with the challenge of seeking ways to contain spiraling costs.

Almost a year ago, I was told of some new alternatives that were being made available to small businesses in my area. I decided to review new strategies concerning coverage with my employees to determine if there was a plan that was more suitable to their needs. Since ultimately I wanted my employees happy with the end result, I made sure all of them were involved in the process and the final decision. What we decided on was a high-deductible health savings account, HSA, plan. The plan offers a $3,000 individual deductible and a $6,000 combined family deductible. I agreed to pay 50 percent of the premium, which amounts to $163 per month for each of my employees. I also agreed to reduce the requirement for participation to a minimum 30-hour workweek. Then participation soared. Even though the cost I paid per employee has gone down, my total cost has increased substantially because of increased staff participation but having an HSA high-deductible option is a win-win for both me and my employees. I am able to offer an affordable option, my employees have a comprehen-

sive health insurance policy and I am able to pay 50 percent of their premiums.

I am not alone as a small business owner struggling to provide health insurance. Every small business owner I know wants to offer affordable, dependable health insurance to their employees and the type of flexibility that will keep them competitive in their respective marketplaces. To ensure this, we call upon Congress to help.

For years the Chamber and businesses like mine have pushed for legislation that would provide relief by letting small businesses pool together across State lines to provide cost-effective and accessible insurance through trade and professional associations. By being part of a larger group, small businesses would have greater negotiating power and would also reduce costs by having uniform standards from State to State. Small businesses need the freedom to purchase plans that meet their employees' needs which means fewer mandates, less bureaucracy and more flexibility.

Congress should also consider proposals that would give tax credits to small businesses to help them provide insurance which would create a level playing field for individuals and the self-employed by giving them deductibility of health insurance premiums.

While I have mentioned several proposals that will help provide some assistance for small business, I also need to discuss the other legislative proposals that would drive down costs and lead to improvements through our healthcare system including the need to promote the widespread adoption of health information technology and to reform our medical liability system.

In conclusion, I encourage Congress to take note of the success that many employers and employees are experiencing by changing our focus from sick care to true health care. Proposals that would offer tax credits to employers who provide comprehensive wellness programs for their employees would be a great help in promoting these efforts.

Thank you for the opportunity to testify today.

[The prepared statement of Ms. Owen follows:]

# Statement
of the
U.S. Chamber
of Commerce

**ON:** **Hearing: America's Need for Health Reform**

**TO:** **The House Committee on Energy and Commerce, Subcommittee on Health**

**DATE:** **September 18, 2008**

The Chamber's mission is to advance human progress through an economic, political and social system based on individual freedom, incentive, initiative, opportunity and responsibility.

The U.S. Chamber of Commerce is the world's largest business federation, representing more than three million businesses and organizations of every size, sector, and region.

More than 96 percent of the Chamber's members are small businesses with 100 or fewer employees, 70 percent of which have 10 or fewer employees. Yet, virtually all of the nation's largest companies are also active members. We are particularly cognizant of the problems of smaller businesses, as well as issues facing the business community at large.

Besides representing a cross-section of the American business community in terms of number of employees, the Chamber represents a wide management spectrum by type of business and location. Each major classification of American business -- manufacturing, retailing, services, construction, wholesaling, and finance – is represented. Also, the Chamber has substantial membership in all 50 states.

The Chamber's international reach is substantial as well. It believes that global interdependence provides an opportunity, not a threat. In addition to the U.S. Chamber of Commerce's 105 American Chambers of Commerce abroad, an increasing number of members are engaged in the export and import of both goods and services and have ongoing investment activities. The Chamber favors strengthened international competitiveness and opposes artificial U.S. and foreign barriers to international business.

Positions on national issues are developed by a cross-section of Chamber members serving on committees, subcommittees, and task forces. More than 1,000 business people participate in this process.

**Statement on**
**"America's Need for Health Reform"**
**Hearing before the**
**THE HOUSE COMMITTEE ON ENERGY AND COMMERCE**
**SUBCOMMITTEE ON HEALTH**
**on behalf of the**
**U.S. CHAMBER OF COMMERCE**
**by**
**Patricia Owen**
**Owner**
**FACES DaySpa**
**September 18, 2008**

Chairman Pallone and Ranking Member Deal, members of the Committee, I am Patricia Owen, owner of FACES DaySpa, a 23-employee small business specializing in cutting-edge spa beauty treatments located in The Village at Wexford, Hilton Head Island, South Carolina. I am pleased to be able to submit the following testimony for the record. I am also here on behalf of the U.S. Chamber of Commerce and serve as a member of its Council on Small Business. The U.S. Chamber of Commerce is the world's largest business federation, representing more than three million businesses and organizations of every size, sector and region. Over ninety-six percent of the Chamber members are small businesses with fewer than 100 employees. I commend the Committee for its interest in having this hearing on health care reform and for acknowledging the challenges facing small business.

I am also a member of the South Carolina Chamber of Commerce, International Spa Association, and the Hilton Head Island Chamber of Commerce where I serve as the Chair of their small business committee.

**Company Background**

As owner of FACES DaySpa, since its inception in 1983, I have guided my company from a small boutique to its current status as a nationally renowned day spa profiled in such major publications as Vogue, Salon Today, Allure and Elle. I began my career in 1977 with Estee Lauder cosmetics in St. Louis, Missouri. Five years later my husband and I decided to move to Hilton Head Island, where we used our hard earned savings to open FACES boutique, featuring Hilton Head's first Estee Lauder cosmetics counter. FACES initially thrived, but the opening of a large mall nearby with its own department store cosmetic counters threatened my small business. FACES needed to evolve to remain competitive and survive, so I decided to expand into professional skincare.

This move was successful and strategically positioned my business in the professional skincare industry – so much so that FACES reached its spa care capacity shortly after the completion of a second spa treatment room. FACES DaySpa is now one of the most extensive day spas in the Southeast, boasting of a wet room, a chemical-free nail studio, a sauna and steam shower and six treatment rooms. In 2004, FACES jumped to the forefront of beauty technology when it partnered with area physicians to become part of the medical spa industry, offering such innovative services as Botox treatments, Laser hair removal and facial rejuvenation and ZOOM teeth whitening.

I am proud to say that FACES has won numerous awards and accolades. The Hilton Head Island Chamber of Commerce named FACES DaySpa its 1996 Small Business of the Year and its 2002 Small Business of the Quarter. Salon Today profiled FACES as "One of the Nation's Fastest-Growing Spas" for five years including 2007. In 2006, I was named SBA South Carolina Small Business Person of the Year. I was also nominated as a finalist in 2005 and 2006 for Enterprising Women of the Year. In 2007, I was named the U.S. Chamber of Commerce, Southeast Regional Finalist, Small Business of the Year. I was also awarded the U.S. Chamber of Commerce Blue Ribbon Small Business Award for three straight years.

**My Health Care Experience**

As owner of FACES, one of my most important duties is to attract and keep highly-qualified employees. It is my employees that carry the banner of our company and maintain the level of customer service that allow us to gain the notoriety and the level of success we have obtained.

I find health coverage is the most sought-after benefit that an employer can offer. Even so, in the Spa industry, it is rare that employers offer any form of health care options to their employees. Thus, the decision to initially commit to providing and subsequently changing the health care coverage offering for my employees at FACES and still remain competitive has been one of the most challenging I have faced. Once committed to providing this benefit, removing it can have a dramatic impact on the level of employee satisfaction, regardless of how unmanageable the costs may become.

So almost five years ago I made the plunge with a traditional PPO health care coverage plan that was made available to full-time employees, those working at least forty hours a week. My company picked up $200 of the cost of the premium and my employees were responsible for the balance.

My experience with this first plan was not positive and it was not well received by the employees. Premiums of older employees were more expensive than that of the younger ones causing them not to participate. Younger workers felt they had little incentive to participate in the plan. Additionally, since it was a new benefit, I required that an employee worked full-time in order for them to qualify for participation. As a result, there was very little participation. Out of my 23 employees only six took advantage of the benefit.

Like most small business owners, I was faced with the challenge of continued soaring annual increases and the challenge of seeking ways to contain these costs in order to stay competitive. On the other hand, I had to be very careful in my decisions to pass on these increases by raising deductibles, lowering coverage, or by implementing a new coverage product that might not have the same appeal.

Almost a year ago I was told of some new alternatives that were being made available to small businesses in my area. So, I decided to revisit and review new strategies concerning coverage with my employees to determine if there was a plan that was more suitable to their needs and expectations. Since ultimately I wanted my employees happy with the end result, I made sure all of them were involved in the process and the final decision. What we decided on was a high deductable Health Savings Account (HSA) plan offered by Starmark Insurance – A Trustmark Company. The plan offered a $3000 individual deductible and a $6000 combined family deductible. I agreed to pay 50% of the premium which amounted to $163 for each of my employees. And they would each pay $163. I also agreed to reduce the requirement for participation from a minimum of a forty-hour work week to a minimum of a thirty-hour work week.

With this new plan in place participation soared. Even though the cost I pay per employee has gone down, my total cost that my company had to pay increased substantially because of the increased numbers.

Having an HSA high deductable option was a win-win for both me and my employees. I am able to offer my 23 employees an affordable option through the HSA. Before finding HSAs as an option, I found myself only available to offer my employees a "one size fits all" policy that was really not affordable or attractive to them or me. With HSAs, my employees have a comprehensive health insurance policy with a high deductible and I am able to pay 50% of their premiums.

Currently, I do not contribute to the savings account feature of this plan and some of my employees have not elected to take advantage of this feature. This is the first year we have had the plan and I feel confident that as we move forward, we will have ample opportunity to explore flexible arrangements and incentives that will make sense to both the company and the employees.

**Additional Policy Positions**

I am not alone as a small business owner struggling to provide health insurance to my employees. Small business owners need to have more options to choose from when purchasing health insurance and the free enterprise system should ensure that affordable health care is available to everyone. A small business should not be penalized for its lack of size or its diversity of workforce. Every small business owner I know wants to offer affordable, dependable health insurance to our employees and the type of flexibility that will keep us competitive in our respective marketplaces. To ensure this, we call upon Congress to help.

Small businesses are the engine that drives our nation's economy and must be a top priority for lawmakers. An overwhelming majority of firms in this country are businesses that employ less than 20 people; and 80 percent of new jobs are created by these small businesses. Many businesses want to offer health insurance, not only because it is good practice that helps them compete for good workers, but because it is the right thing to do. Congress can, and should, consider legislation that can help small business owners like me.

For years the Chamber and businesses like mine have pushed for legislation that would provide relief by letting small businesses pool together – across state lines – to provide cost effective and accessible insurance through trade and professional associations. By being part of a larger group, small businesses would have greater negotiating power and would also reduce costs by having uniform standards from state to state. Another proposal with merit would be to create a national market for health insurance that would allow employers and individuals to buy insurance from a state other than their own, which would help with unnecessary state mandates and regulation. Small businesses need the freedom to purchase plans that meet their employees' needs, which means fewer mandates, less bureaucracy, and more flexibility. I also want to mention a newly introduced proposal called the "Small Business Cooperatives for Healthcare Options to Improve Coverage for Employees Act of 2008 (CHOICE)." The CHOICE Act provides a new approach by using a reinsurance concept to spread risk, lower premium volatility, protect the solvency of primary insurers, and help control costs for small businesses.

Congress should also consider proposals that would provide tax credits to small businesses to help provide insurance, and would create a level playing field for individuals and the self-employed by giving them deductibility of health insurance premiums. Congress can also take a look at improving Health Savings Accounts, to which 4 million Americans have already subscribed. Giving more flexibility to funding and using these accounts will make the products, which are an affordable alternative to traditional PPO plans, more attractive to employers and employees. I am also supportive of legislation that would amend the Internal Revenue Code to allow small businesses to set up simple cafeteria plans to provide nontaxable employee benefits to their employees, to make changes in the requirements for cafeteria plans, flexible spending accounts, and benefits provided under such plans or accounts.

While I have mentioned several proposals that would help provide some assistance for small businesses, I also feel the need to discuss other legislative proposals that will help drive down costs and lead to improvements throughout our health system, including the need to promote the widespread adoption of health information technology and to reform our medical liability system. Also needed in our health care system are improvements to Medicare and Medicaid reimbursements that place greater emphasis on incentives for quality and outcomes.

Lastly, I encourage Congress to take note of the success that many employers and employees are experiencing by changing our focus from "sick care" to true "health care"

through preventative health care. The Chamber believes that this is the only way to achieve true savings in our health system. Proposals that would offer tax credits to employers who provide comprehensive wellness programs for their employees would be a great help in promoting these efforts. Toward that end, the Chamber is leading efforts to encourage maximum business participation in wellness programs that enhance healthy lifestyles of employees and their dependents through the establishment of the U.S. Workplace Wellness Alliance, an alliance of more than 50 organizations who have joined forces to encourage greater focus on comprehensive wellness.

Thank you for the opportunity to testify today. As a small business owner, I look to you to continue to protect small business' ability to be competitive and to create jobs by solving one of our biggest challenges. Fixing our nation's health care system is no easy task, but I hope it is one you will carefully deliberate and constructively approach in this Congress.

Mr. PALLONE. Thank you, Ms. Owen. I particularly appreciate your explaining just how it works, you know, what the direct impact is on the employees.

Ms. Pollitz.

**STATEMENT OF KAREN POLLITZ, M.P.P., PROJECT DIRECTOR, RESEARCH PROFESSOR, GEORGETOWN UNIVERSITY HEALTH POLICY INSTITUTE**

Ms. POLLITZ. Thank you, Mr. Chairman, Congressman Deal. Good morning, members of the subcommittee. I am Karen Pollitz and I direct research on private health insurance at Georgetown University's Health Policy Institute and I will focus my remarks this morning on private health insurance and the role it might play in any health reform proposal.

Mr. Chairman, we buy health insurance in case we get sick. Therefore, how private health insurance works for us when we are sick is of the utmost concern. In order for insurance protection to be meaningful, it has to satisfy four tests. It must be available, adequate, and affordable always, and too often today private health insurance fails one or more of these tests. We have to do better.

First, coverage must be available. That means we have to be eligible to enroll. Today the vast majority of uninsured people work but are ineligible for either job-based coverage or Medicaid or other public programs so their option is individual health insurance. However, this coverage is medically underwritten in most States and so you are not eligible if you are not in perfect health. Cancer, diabetes, heart disease, pregnancy, and many other conditions will render you uninsurable, and even minor health conditions like hay fever or acne can get you into trouble. If we want health insurance to be available to people when they are sick, we need regulation to require that all policies be sold all the time on a guaranteed issue basis.

Second, health coverage must be adequate. The measure of adequacy is the out-of-pocket costs for medical care that people must pay after their insurance has contributed. Too often today, health insurance is inadequate. Medical debt and medical bankruptcy are primarily problems of the insured. A recent Commonwealth Fund study found that the number of underinsured Americans has grown 60 percent since 2003. Numerous health plan features can leave people inadequately covered, especially in the individual health insurance market. In particular, preexisting condition exclusion periods will carve out the very coverage that people need most. Barebones policies that don't cover doctor visits, chemotherapy, mental health care, maternity care, or prescription drugs are also problematic. Very often, cost sharing for covered services is what gets people into trouble. High deductibles are one obvious cost burden but so can be even most copays. Don't forget that the majority of healthcare spending is due to chronic conditions, and for these patients, cost sharing can be relentless. So, for example, over the course of 18 months of active treatment, a breast cancer patient might have as many as 180 doctor visits and outpatient therapies and need as many as 40 prescriptions and refills. A $25 copay for each of these would total more than $5,000.

Adequacy of health insurance can be addressed through regulation. We have to rethink our definition of private health insurance. Under federal law, the definition of health insurance is pretty much anything a health insurance company sells. We need a better outcomes-based definition. A policy that leaves you bankrupt or in debt if you have a baby or cancer or heart attack should not be allowed to be called health insurance.

Third, insurance premiums have to be affordable. Plenty of policies in the individual market today sell for less than $100 a month but only because coverage is skimpy and sick people aren't allowed to buy them. If we want insurance to cover people and the care they need, it won't be inexpensive and many people will need subsidies, significant subsidies in order for their coverage to be affordable. In addition to subsidies, regulation is needed to prevent insurers from varying premiums based on health status, age, gender, and other factors. The experience of the tax credit we have today for health insurance, the health coverage tax credits, is instructive. Under that law, coverage can be made available to people and eligible for the credit that isn't subject to any rating rules. In the State of North Carolina, one insurer charged more than $3,900 per month for an HCTC-eligible policy for a 55-year-old in poor health. Even with a 65 percent subsidy, few could afford to pay the rest.

Finally, health insurance must be available, affordable, and adequate all of the time, and here again, rules will be needed so that people can not only get coverage but keep it. Especially in the individual health insurance market, it can be very hard to remain covered once you get sick. If cherry picking describes the practices the insurers use to select only good risks at the outside, then lemon dropping might be used to describe practices to shed risks once they are enrolled. Premiums can take off at renewal when companies use durational rating or when they close a product to new policyholders, stranding the in-force enrollees in a dwindling pool whose premiums just climb. Recent press accounts have also taught us about the practice of post-claims underwriting under which policyholders who make claims may be re-investigated to determine whether the insurer can avoid paying the claim. These investigations are defended as necessary to defer fraud but abuse of insurer practices has also been documented including accounts of one carrier that paid bonuses to staff based on how many individual policyholders were dropped and how much money was saved.

Mr. Chairman, I acknowledge that regulation isn't always very popular and I just have ticked off a pretty good list of rules, but believe me, these are necessary, and in fact, I should probably add a fifth A to my list, accountability. If we want to expend health insurance coverage and retain a role for private insurance companies, particularly in the individual market, you will need much tighter regulation that you have today. Even under health reform with mandate for everyone to have coverage and generous subsidies, the incentive to cherry pick and lemon drop will continue.

Make no mistake, there will always be an incentive for insurers to avoid that small minority of us who account for most healthcare spending and at some point all of us will spend some time in that

minority. Strong national federal standards for health insurance will be critical to ensure that all Americans——

Mr. PALLONE. Ms. Pollitz, you are a minute over.

Ms. POLLITZ. And I am winding up. We will also need the expertise and capacity of state regulators to help enforce and monitor strong national protections. It is time for this Nation to move ahead on a program of healthcare to ensure that coverage is always available, afford and adequate for all of us. Thank you.

[The prepared statement of Ms. Pollitz follows:]

GEORGETOWN UNIVERSITY

HEALTH POLICY INSTITUTE

"America's Need for Health Reform"

Statement of

Karen Pollitz, Research Professor
Georgetown University Health Policy Institute

before the

Subcommittee on Health

Committee on Energy and Commerce

September 18, 2008

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Good morning Chairman Pallone and Members of the Subcommittee.

Thank you for convening this hearing on the need for national health care reform. My name is Karen Pollitz. I am a Research Professor at Georgetown University's Health Policy Institute, where I have directed research on private health insurance regulation for twelve years. I am pleased to provide testimony on the role that individual health insurance might play in any meaningful health reform program.

I would begin with a few simple statements that, I hope, can garner broad agreement, and perhaps steer a course for the discussion this morning.

We buy health insurance in case we get sick. Therefore, how private health insurance works for us *when* we are sick is of the utmost concern. Health insurance is our ticket to health care. In order for the promised protection of health insurance to be meaningful, it must satisfy four tests.

Availability

First, health insurance must be available. That means we must be eligible to enroll. Today, eligibility for health coverage is largely derived from other factors -- our work status, family status, age, income, where we live, and so on. Most non-elderly Americans are covered by job-based group health plans because they are eligible for employment health benefits in their own right or as the spouse or dependent of an employee. The majority of uninsured Americans also work, but they are not offered health benefits or are not eligible to participate in the employer health plan.

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Safety net public programs – primarily Medicaid and S-CHIP – offer coverage for millions of low-income persons. Yet, Medicaid coverage is not available to most uninsured low-income adults because they do not meet program categorical and income eligibility rules.

People who are not eligible for job-based coverage or Medicaid – that is, most of the uninsured – can seek coverage in the individual health insurance market. However, medically underwritten coverage in this market conditions eligibility on health status, and so tends not to be available to applicants who are sick or otherwise need health care. Dozens of health conditions – from cancer, to diabetes, to pregnancy – render people "uninsurable" in most states. People also may be unable to buy individual coverage if they have a history of health problems. Even minor health conditions, such as hay fever or acne, can trigger a denial by some insurers.[1]

Only a relatively small proportion of the non-elderly are covered by individual health insurance at any point in time. (See Figure 1) However, over a three-year period, one-in-four adults seek coverage in this market, most without success.[2] That makes individual health insurance the weak link in the health coverage chain today. Two million Americans lose or change health insurance each month. Those who need individual policies when they are sick or after they've been sick may not find coverage available to them.

Improving the availability of private health insurance can be and has been addressed through regulation. Some states require individual health insurance to be sold on a "guaranteed issue" basis. That means applicants cannot be turned down because of health status. Federal law

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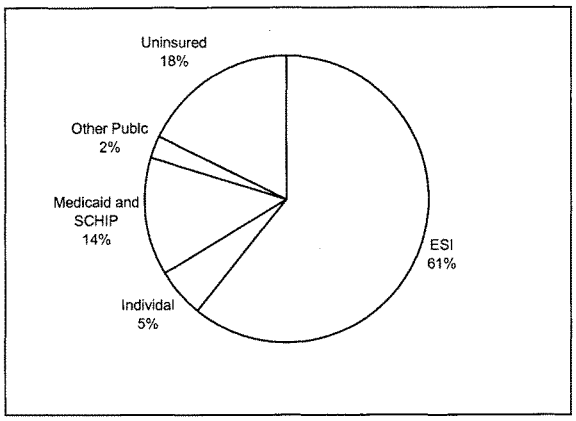
[1] See, for example, K. Pollitz, R. Sorian and K. Thomas, "How accessible is Individual Health Insurance for Consumers in Less than Perfect Health?" Henry J. Kaiser Family Foundation, June 2001. See also D. Grady, "After Caesareans Some See Higher Insurance Cost," *New York Times,* June 1, 2008.

[2] L. Duchon, et. al., "Security Matters: How Instability in Health Insurance Puts U.S. Workers at Risk," The Commonwealth Fund, December 2001. See also J. Hadley and J. Reschovsky, "Health and the Cost of Nongroup Insurance," *Inquiry,* Volume 40, Number 3. Fall 2003.

(HIPAA) requires individual health insurance to be sold on a guaranteed issue basis to certain eligible individuals when they leave job-based group coverage. That same federal law requires that all policies sold to small employers must be offered on a guaranteed issue basis.

**Figure 1. Sources of Health Coverage, Non-Elderly**




Source: Urban Institute estimates of March 2007 Current Population Survey, U.S. Census Bureau

If the individual market is to play a role in any coverage expansion strategy, policies must be available to all individuals without regard to their health or risk status.

Adequacy

Health insurance coverage must also be adequate. Adequacy must be measured against the health needs of people who are sick, pregnant, or in need of other expensive care or treatment. Adequate health insurance must ensure that people can obtain needed care without owing more than a manageable level of costs out-of-pocket. One recent study suggested that people may be underinsured if out-of-pocket medical expenses reach ten percent of income or higher (five percent for persons with incomes below 200 percent of the poverty level), or if deductibles

constitute five percent of income or more.[3] Evidence suggests the problem of underinsurance is serious; medical debt and medical bankruptcy are primarily problems of the insured.[4] Coverage adequacy problems tend to be worse in the individual market, where policies are less comprehensive compared to job-based health plans.[5] A recent survey of Midwestern farm and ranch operators (who rely disproportionately on individual health insurance) found that people covered by individual policies were more than twice as likely to be burdened by high out-of-pocket costs and medical debt compared to those covered under employer-sponsored group health plans.[6]

Numerous health plan features can affect adequacy of coverage:

- Pre-ex exclusions and riders – Most private health insurance policies will temporarily exclude coverage for a new enrollee's pre-existing condition. In the individual market, insurers in most states can also amend policies with riders that permanently exclude coverage for an applicant's health condition, or for the body part or system it affects.
- Covered and excluded benefits – Insurers in most states have broad flexibility to design policies to cover or exclude specific benefits. Especially in the individual market, it is possible to find many policies that do not cover, or that strictly limit coverage for, key health services such as medical office visits, chemotherapy, mental health care, maternity care, and prescription drugs.

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[3] C. Schoen et. al., "How Many Are Underinsured? Trends Among US Adults, 2003-2007," *Health Affairs,* Web Exclusive, June 10, 2008.
[4] D. Himmelstein, E. Warren, et. al., "Illness and Injury as Contributors to Bankruptcy," *Health Affairs,* Web Exclusive, February 2, 2005. See also J. May and P. Cunningham, "Tough Trade-offs: Medical Bills, Family Finances and Access to Care," Center for Studying Health System Change, June 2004. See also, H. Tu, "Rising Health Costs, Medical Debt, and Chronic Conditions," Issue Brief No. 88, Center for Studying Health System Change, September 2004.
[5] J. Gabel, et. al., "Individual Health Insurance: How Much Protection Does it Provide?" *Health Affairs,* Web Exclusive, April 17, 2002.
[6] "Who Experiences Financial Hardship Because of Healthcare Costs?" The Access Project, Issue Brief No. 3, September 2008, available at www.accessproject.org

- Cost sharing – Typically patients must pay at least a portion of the cost of covered services through deductibles, co-pays and coinsurance. High deductible health plans have become more common, particularly in the individual market. While some urge that high deductibles will promote more cost conscious use of health care by patients, in fact, research shows high deductibles deter use of necessary care, as well.[7] Further, high-deductible plans are unlikely to curb health spending overall because most health care spending arises from conditions whose treatment costs far exceed the level of health plan deductibles.[8]

  High deductibles and other cost sharing will, however, shift cost burdens onto seriously ill patients. Further, those with chronic conditions (who account for 75 percent of health care spending)[9] will feel this burden year after year. Even modest co-pays can mount relentlessly. For example, over 18 months of active treatment, a breast cancer patient might have as many as 165 doctor visits and outpatient treatments and require up to 40 prescriptions and refills.[10] If a co-pay of $25 applied for each, her expenses due to co-pays alone would exceed $5,000. Most policies provide for an annual out-of-pocket maximum, but this cap may be porous; in particular, co-pays may not count toward the limit.

- Other coverage restrictions – Additional features that may be less obvious and less easy for patients to investigate can also limit what is covered. Tiered provider networks mean patients may pay more, or all, of expenses for covered services depending on where care

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[7] R. H. Brook, et.al., "The Health Insurance Experiment: A Classic RAND Study Speks to the Current Health Care Reform Debate," RAND Research Brief RB-9174-HHS, 2006.

[8] See, for example, L. Blumberg and L. Burman, "Most Households' Medical Expenses Exceed HSA Deductibles," *Tax Notes*, August 16, 2004.

[9] For example, most nine-month pregnancies will span two years. A recent study of out-of-pocket spending for maternity care under consumer driven health plans found patients might be liable for as much as 80 percent of the cost of their care when pregnancy is covered under two different plan years. See K. Pollitz, M. Kofman, A. Salganicoff, and U. Ranji, "Maternity Care and Consumer-Driven Health Plans," Henry J. Kaiser Family Foundation, June 2007.

[10] Georgetown University Health Policy Institute, estimated costs of care for various serious and chronic health conditions, unpublished.

> is rendered, with higher cost sharing applied to more specialized services. Tiered formularies vary cost sharing depending on the cost of drugs. These policy features exist for cost containment purposes, but also can have the effect of shifting cost burdens to the sickest patients. Further, their impact may not be obvious to consumers until they get sick and experience firsthand how their coverage works.

Adequacy of health insurance can also be addressed through regulation. Most states have addressed adequacy only incrementally, through mandated benefit laws. Some states have gone beyond discreet benefit mandates to define more broadly the covered benefits and cost sharing limits that licensed insurers must provide.[11] By contrast, federal law provides very little guidance on coverage adequacy, defining health insurance as "benefits consisting of medical care...under any hospital or medical service policy or certificate...offered by a health insurance issuer."[12] A more comprehensive definition of health insurance is needed. Coverage that is inadequate should not be called health insurance.

Affordability

Health insurance premiums must also be affordable. Premiums for private coverage vary widely today, driven largely by differences in the availability and adequacy of policies. Policies that exclude sick people or coverage for key health benefits will have lower premiums relative to policies that are available and adequate; but we must not be distracted by this comparison of unlike products. Rather, we must accept the fact that health insurance, which covers people and their needed health care, will be expensive. Per capita health care spending in the U.S. is

[11] Massachusetts, New York, New Jersey, Maine, and Vermont are examples of states that have adopted such standards.
[12] Section 2791 (b), Public Health Service Act.

roughly $7,000.[13] By contrast, median household income is just over $50,000.[14] Therefore, significant subsidies will be needed in order for coverage to be simultaneously affordable, adequate and available.

In addition to subsidies, insurance market regulation is needed to prevent insurers from varying premiums based on health status, age, gender, and other factors. The experience of the Health Coverage Tax Credit (HCTC) is instructive. Congress provided for a variety of possible qualified coverage arrangements but no rating standards. In a number of states, HCTC-qualified coverage includes individual market policies that are not subject to rating limits. For example, in North Carolina, individual policy premiums for a 55-year-old with serious health conditions were found to be as high as $3,926 per month.[15] Even with a 65 percent tax credit, this policy was unaffordable.

Always

Finally, health insurance must be available, affordable, and adequate all of the time. Nearly 40 percent of non-elderly Americans experience a spell of uninsurance at some point over a three-year period.[16] If we are to continue with our current, pluralistic coverage system, we will have to provide mechanisms to make continuous coverage possible even as people move from plan to plan.

Regulation must also address insurance industry practices that make it difficult for people to remain enrolled in coverage once they get sick. These practices have been described as "lemon

[13] Center for Medicare and Medicaid Services, National Health Expenditure Accounts, 2006.
[14] U. S. Bureau of the Census.
[15] S. Dorn, T. Alteras, and J. Meyer, "Early Implementation of the Health Coverage Tax Credit in Maryland, Michigan, and North Carolina: A Case Study Summary," The Commonwealth Fund, April 1, 2005.

[16] P. Short, D. Graefe, and C. Schoen, "Churn, Churn, Churn: How Instability of Health Insurance Shapes America's Uninsured Problem," The Commonwealth Fund, November 2003.

dropping" (in contrast to "cherry picking," which refers to practices that deter initial enrollment.) Several renewal rating practices fall into this category. "Experience rating" increases premiums at renewal for policyholders who have made claims. More common in the individual market, "durational rating" increases premiums for all policyholders over time and prompts those who remain healthy to resubmit to medical underwriting in order to escape renewal rate increases. Many insurers also engage in a practice known as "closing a block" of business. This means the insurer ceases to actively market a policy to new enrollees. Without an influx of newly underwritten healthy enrollees, the average cost experience of in-force policyholders increases dramatically until premiums reach prohibitive levels. Current federal law requirements of guaranteed renewability laws dictate that policyholders must be allowed to remain eligible for coverage, but not that coverage remain affordable over time.[17]

"Post-claims underwriting" triggers another category of practices that can threaten the availability, affordability, and adequacy of coverage over time. Policyholders who make claims for expensive health conditions after they enroll may be investigated to determine when the condition first appeared and whether it was disclosed. Insurers may exclude coverage for conditions determined to be pre-existing, in some cases even if they were disclosed during the underwriting process. Post-claims underwriting may also result in the retroactive imposition of exclusion riders or premium surcharges; or coverage may be cancelled or rescinded. Post-claims investigations are defended as necessary to deter consumer fraud, but abusive insurer practices have also been documented, including recent reports that one carrier paid staff bonuses based in part on how many individual policyholders were dropped and how much money was saved.[18]

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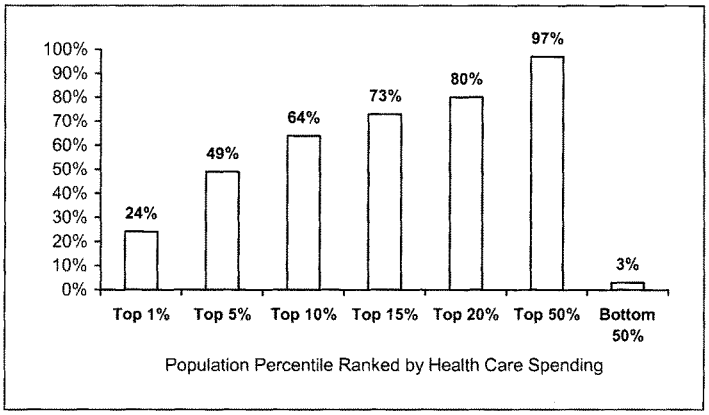
[17] "On their Own: Far from a remedy, individual health insurance is a world of pain," *Consumer Reports*, January 2008

[18] L. Girion, "Health insurer tied bonuses to dropping sick policyholders," *Los Angeles Times,* November 9, 2007.

Oversight and Transparency

Even under health reform that provides for mandatory universal coverage and generous subsidies, the incentive to "cherry pick" and "lemon drop" will persist. The distribution of health expenses across the population makes this inevitable. It will always be more profitable for insurers in a competitive market to avoid that small proportion of the population who account for the lion's share of health care spending. (See Figure 2) Therefore, strong rules must be created and enforced to create a level playing field.

**Figure 2. Concentration of Health Spending in the U.S. Population**




Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2003.

Federal standards for health insurance will be critical to ensure that all Americans enjoy health insurance protections, no matter where they live. In light of states' more extensive regulatory experience and infrastructure, the federal government will likely need to work cooperatively with state insurance departments to implement national standards. However, the federal government

also needs its own independent capacity to exercise oversight of the health insurance industry, monitor state enforcement, and provide for direct enforcement when or if states do not.

Improved transparency of health insurance is also necessary to make markets function well. Health coverage must become more readily obvious and understandable to consumers and patients. A blizzard of varying policies offered today leaves consumers confused as to the type of health insurance they have.[19] Two seemingly similar policies may offer vastly different levels of coverage because the definition of covered benefits, the application of cost sharing rules, and other policy features vary. Fine print and jargon further obscure how coverage works. While unlimited variation in health plan features may seem, at first blush, to expand choices for consumers, it also permits insurers to obscure limitations in coverage in ways consumers might never think to investigate until it is too late. Standardization can take much of the guesswork out of coverage and reduce opportunities for abuse. Standardizing coverage will also reduce adverse selection. And if all policies offer comprehensive protection, nobody will be under-insured.

The creation of "health insurance exchanges" or "connectors" can help ensure that policies comply with standardized rules and offer consumers objective comparative information about plan choices. Exchanges or connectors can also play a critical role in administering coverage subsidies.

Conclusion

Mr. Chairman, it is time for this nation to move ahead on a program of health care reform to ensure that all people enjoy health coverage that will take care of them when they are sick – and that is available, adequate, and affordable all of the time. We won't reach this goal by

[19] D. Nelson et.al., "What People Really Know About Their Health Insurance: A Comparison of Information Obtained from Individuals and Their Insurers," *American Journal of Public Health,* Vol. 90, No. 6, June 2000.

happenstance. Rather, these goals must guide our public policy decisions and design. As you contemplate the next round of health reform, one key question is whether it makes sense to continue a role for a competitive, private health insurance market and, in particular, an individual market. If we agree health coverage must always be available, affordable, and adequate for everyone, then we must ask whether the health insurance industry is up to this task. Over the years it has been argued that carriers must engage in the practices just described if they are to remain viable and offer coverage for affordable premiums. Yet too often, these business practices collide with public health needs. When health insurance fails people who are sick, they cannot get the care they need.

Coverage expansion might be achieved through individual health insurance, though not the

GEORGETOWN UNIVERSITY

POLICY INSTITUTE

"America's Need for Health Reform"

Statement of
Karen Pollitz, Research Professor
Georgetown University Health Policy Institute
before the
Subcommittee on Health
Committee on Energy and Commerce
September 18, 2008

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markets we have today. Continued reliance on individual health insurance will require

substantial change if we want such coverage to provide meaningful protection that guarantees all Americans access to care when we need it.

Mr. PALLONE. Thank you, and I know you have been here on other occasions and we always like to hear from you, believe me. Thank you.

Dr. Davis.

**STATEMENT OF KAREN DAVIS, PH.D., PRESIDENT, THE COMMONWEALTH FUND**

Ms. DAVIS. As members have stressed today, it is important to lay the foundation for health reform, and in doing that, I think it is instructive to look at the 40-year history of Medicare and Medicaid and our 10 years of experience with SCHIP, the State Children's Health Insurance Program. These programs cover America's sickest and poorest individuals, people who do not fare well in the private insurance market. Currently more than one in four Americans are covered under public programs.

As the Nation moves to cover the uninsured, preserving a mixed private-public system of coverage has many advantages. First of all, it minimizes disruption in current sources of coverage, but most importantly, it can build on both the strengths of public programs and private coverage, and it requires only minimal new administrative structures.

To turn to public programs, they are especially valuable components of health reform. First and foremost, they have low administrative costs. They have a track record of providing access to needed healthcare services for those who are most difficult to serve. Medicare in particular is an ideal coverage source for older and disabled adults in the two-year waiting period for Medicare because these individuals will soon be eligible for Medicare and they typically cannot find coverage in the individual insurance market since insurers have a strong financial incentive to restrict enrollment or limit benefits of those with health problems. Opening up Medicare to older adults and the disabled in the 2-year waiting period has many advantages. It helps them get affordable coverage but it also helps prevent health conditions from deteriorating and resulting in even higher costs to Medicare once they do become eligible, and work that we have funded at the Commonwealth Fund and published in leading medical journals has documented that. Medicare beneficiaries report high satisfaction with their coverage and their ability to access healthcare services.

Medicaid and SCHIP are also ideal sources of coverage for low-income adults and children. They often serve as a source of coverage for many of the Nation's most seriously disabled, children with developmental disability, HIV/AIDS, frail elders, and others. States have been successful in reducing the rate of uninsured children since the SCHIP program was enacted in 1997. States' ability to do this, however, depends on how the economy is doing and may be subject to retrenchment in economic downturn, and as Governor Corzine pointed out, it is very important that the federal matching rate for Medicaid and SCHIP increase and be adjusted automatically with rates of unemployment.

Private employer coverage is also very important to the American health insurance systems. It covers 160 million working Americans and their families. Employers tend to pick up 75 to 80 percent of the premium. However, it is the small business sector

where coverage is eroding and in part that is because small firms cannot get the same premiums that are available to large firms for the same benefits.

For those individuals whose only recourse is the individual insurance market, as Karen Pollitz has pointed out, availability and affordability depend on State regulation. Our studies show that nine out of ten people who look for individual health insurance don't buy it. They don't buy it because it is not available to them, they can't afford it, or it doesn't meet their needs. So we do need a set of national rules and a national insurance connector that assures affordability for coverage.

Congress can take steps now to lay the foundation for broader health reform. These include leverage Medicare's position as the largest payer for healthcare, to improve healthcare quality, and address the rise in healthcare costs that have been mentioned by a number of our panelists. It can also strengthen Medicaid and SCHIP as the basis for coverage for all low-income children, and I would say adults, reforming individual markets and making affordable insurance options including a public insurance option modeled on Medicare available to small businesses and individual through an insurance connector.

A mixed private-public system of universal coverage featuring seamless coordination across sources of coverage could transform both the financing and delivery of healthcare services. Such a system would build on the best that both private insurance and public programs have to offer while achieving needed savings and ensuring access to care for all.

Thank you.

[The prepared statement of Ms. Davis follows:]


# USING WHAT WORKS: MEDICARE, MEDICAID, AND THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM AS A BASE FOR HEALTH CARE REFORM

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**Invited Testimony at Hearing on "America's Need for Health Reform"**
**House Committee on Energy and Commerce**
**Subcommittee on Health**
**September 18, 2008**

## EXECUTIVE SUMMARY

As the nation begins serious consideration of health reform, it is instructive to review the contributions of Medicare and Medicaid over their 40-year history of covering the sickest and poorest Americans—those who typically do not fare well in private insurance markets. These two programs, together with the more recently enacted State Children's Health Insurance Program (SCHIP), have provided many of our most vulnerable citizens with improved access to health care and greater financial protection. Because of their success, they warrant serious consideration as building blocks for a new system of seamless coverage for America's 46 million uninsured people.

Currently, more than one of four Americans, or some 83 million people, are covered by Medicare, Medicaid, SCHIP, or other public programs. About three of five Americans are insured by private insurance—mostly employer coverage—while 15 percent are uninsured. As the nation moves to cover the uninsured, preserving a mixed private–public system of coverage has many advantages: 1) it minimizes disruptions in current coverage; 2) it can build on the strengths of public programs and private coverage; and 3) it requires only minimal new administrative structures.

Public programs can be especially valuable components to health reform. For one, they have low administrative costs and a track record of providing access to needed health care for those who are the most difficult to serve. Medicare, in particular, is an ideal coverage source for older and disabled adults without employer insurance who will transition to Medicare coverage once they turn 65 or are disabled for two years. Such individuals are rarely able to obtain affordable private coverage, since insurers in the individual market have a strong financial incentive to restrict enrollment or limit the benefits of people with serious health problems. Opening up Medicare to these at-risk adults could help prevent serious health conditions from deteriorating and resulting in higher costs to Medicare once they become eligible. Medicare beneficiaries report high satisfaction with their coverage and their ability to access health care services.

Medicaid and SCHIP are also ideal coverage sources for low-income adults and children. These programs often serve as the source of coverage for those with the most serious health problems—children with developmental disabilities, adults with HIV/AIDS, frail elders, and others with serious physical and mental disabilities. SCHIP has been highly successful in reducing the rate of uninsured children; most states have responded to the offer of favorable federal matching by expanding their coverage of low-income children. States' ability to this, however, depends on how the economy is doing, and may be subject to retrenchment in economic downturns.

Private employer insurance now covers 160 million working Americans and their families. For the most part, employer coverage works well for those Americans whose employers contribute an average of 75 to 80 percent of the plan premium. However, coverage has become increasingly unaffordable for small firms, which are unable to obtain the same benefits at the premium rates paid by larger firms.

For those individuals whose only recourse is the individual insurance market, the availability and affordability of coverage depend heavily on state regulation. Of those who seek coverage in the individual market, about nine of 10 do not buy a plan—because it is difficult or impossible to find a plan that is affordable, because they are turned down, or because they cannot find a plan that meets their needs.

Congress can take steps now to lay the foundation for broader health reform that ensures affordable coverage for all Americans. These include: 1) leveraging Medicare's position as the largest payer for health care to improve health care quality and slow the growth in health care costs; 2) strengthening Medicaid and SCHIP to serve as a base of coverage for all low-income children and adults; 3) reforming individual insurance markets; and 4) making affordable insurance options, including a public insurance option, available to small businesses and individuals through an insurance connector.

Medicare can be a leading force for change in the health care system. It can serve as a model for private insurers in public reporting, rewarding quality, requiring evidence-based care, and encouraging the use of modern information technology. Reforms to Medicare's payment system could improve the accessibility and coordination of care through patient-centered medical homes; help shape a more organized, higher-performing health system; and create incentives for delivering care more efficiently, for example, by preventing avoidable hospitalizations. If initiated early, such reforms could slow the growth in health care costs and "bend the curve" in national health expenditure trends.

Reauthorization and adequate funding of SCHIP are essential steps to covering many of the nation's 8 million uninsured children. Medicaid programs could be strengthened by providing a counter-cyclical federal matching rate that adjusts automatically in times high unemployment, when states undergo serious financial strains. States should also have an incentive to learn from each other—to spread the latest innovations and best practices in information technology, pay-for-performance, patient-centered medical homes, and chronic care management.

Finally, insurance market reforms—including minimum requirements on insurers to cover both the sick and the healthy at the same premium—could ensure the availability of coverage in all states. By organizing a national insurance connector that draws from the experience of Massachusetts, we could expand insurance choices to small businesses and individuals. With more integrated benefits and innovative payment policies, a Medicare-sponsored public plan could also be offered as an option to small businesses and individuals.

A mixed private–public system of universal coverage featuring seamless coordination across sources of coverage could transform both the financing and delivery of health care services. Such a system would build on the best that both private insurance and public programs have to offer while achieving needed savings and ensuring access to care for all.

# USING WHAT WORKS: MEDICARE, MEDICAID, AND THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM AS A BASE FOR HEALTH CARE REFORM

**Karen Davis and Cathy Schoen**
**The Commonwealth Fund**

Thank you, Mr. Chairman, for this invitation to testify regarding the role of public programs in health reform. As this Committee knows well, public programs today cover more than one of four Americans—83 million people—including elderly and disabled adults under Medicare; low-income families, the elderly, and the disabled under Medicaid; and low-income children under the State Children's Health Insurance Program (SCHIP). Covering many of the sickest and poorest Americans, these programs have improved access to health care for those who typically do not fare well in a private insurance market. They warrant serious consideration as building blocks in a system of seamless coverage for America's 46 million uninsured people.

Congress can take steps now to lay the foundation for broader health reform that ensures affordable coverage for all Americans. These include: 1) leveraging Medicare's position as the largest payer for health care to improve the quality of care and slow the growth in health care costs; 2) strengthening Medicaid and SCHIP to serve as a base of coverage for all low-income children and adults; 3) reforming individual insurance markets; and 4) making affordable insurance options, including a public insurance option, available to small businesses and individuals through an insurance connector.

If initiated early and combined with strategic policies aimed at quality and efficiency, these reforms could slow the growth in health care costs and "bend the curve" in national health expenditure trends.[1] In doing so, a mixed private–public system of universal coverage that features seamless coordination across sources of coverage could transform both the financing and delivery of health care services. Such a system would

[1] C. Schoen, S. Guterman, A. Shih, J. Lau, S. Kasimow, A. Gauthier, and K. Davis, *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending* (New York: The Commonwealth Fund, Dec. 2007).

build on the best that private insurance and public programs have to offer while achieving needed savings and ensuring access to essential care for all.[2]

**The Uninsured**

Last month, the U.S. Census Bureau released the latest data on the number of Americans without health insurance. The number of uninsured individuals fell to 45.7 million in 2007, from 47.0 million in 2006.[3] While the new figure represents the first decline since 1999, there are still 7 million more uninsured people now than at the beginning of the decade. And these statistics fail to count the millions more who experience lapses in their coverage during the year, or the millions of "underinsured" people whose inadequate coverage ensures neither access nor financial protection.[4]

The new census data show the importance of the nation's safety-net insurance system—Medicaid and SCHIP. The decline of 1.3 million uninsured people between 2006 and 2007 was entirely attributable to an equal growth in coverage under Medicaid. In contrast, employment-based coverage declined slightly, from 59.7 percent of the population to 59.3 percent.

The major bright spot in the last eight years has been the improved rate of coverage for children, with the proportion of uninsured children declining from 12.5 percent in 1999 to 11.0 percent in 2007. This improvement was a reflection of increased coverage for children under SCHIP. However, more than 8 million children remain uninsured, which highlights the importance of permanent reauthorization of the SCHIP program and adequate funding to cover all low-income children.

By contrast, the proportion of uninsured adults ages 18 to 64 has increased markedly since 1999, from 17.2 percent to 19.6 percent. The gap between coverage rates for working-age adults and children has widened in the last eight years—in contrast with the 1990s, when rates for both rose in concert. The differential experience for adults, who

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[2] C. Schoen, K. Davis, and S. R. Collins, "Building Blocks for Reform: Achieving Universal Coverage with Private and Public Group Health Insurance," *Health Affairs,* May/June 2008 27(3):646–57; K. Davis, C. Schoen, and S. R. Collins, *The Building Blocks of Health Reform: Achieving Universal Coverage and Health System Savings* (New York: The Commonwealth Fund, May 2008).

[3] C. DeNavas-Walt, B. Proctor, and J. Smith, *Income, Poverty, and Health Insurance Coverage in the United States: 2007* (U.S. Census Bureau, Aug. 2008).

[4] C. Schoen, S. Collins, J. Kriss and M. M. Doty, "How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007," *Health Affairs* Web Exclusive, June 10, 2008, 27(4).

were not covered by SCHIP, attests to the success of offering states fiscal incentives to cover low-income children. Extending federal financial assistance to states to cover low-income adults could have a similar impact in alleviating some of the most serious health care access problems created by gaps in coverage.

Some states have stepped up to the plate to find ways to cover both children and adults who are uninsured. Massachusetts, which enacted health reform in April 2006 with the help of a Medicaid waiver, has moved into first place, with the lowest uninsured rate in the nation in 2007. In that state, 7.9 percent of the population was uninsured in 2006–2007, compared with 24.8 percent in Texas, the state with the highest uninsured rate. A recent report from the Massachusetts Commonwealth Connector indicates that 439,000 residents have obtained coverage under the Massachusetts health insurance reforms.[5]

Despite success stories such as the one in Massachusetts, most states have not been able to move forward without federal financial assistance, even when governors have proposed ambitious health reform plans. Most of the uninsured have low incomes and cannot contribute in a significant way to today's health insurance premiums that, even under employer-based plans, run over $12,000 for a family.[6] Sixty-two percent of the uninsured have incomes below $50,000, and 80 percent have incomes below $75,000.[7] Without employers or government paying a substantial part of premiums, few uninsured families could afford to pay a $12,000 premium on their own. Even at an income of $75,000, typical group-rate health insurance premiums would consume 16 percent of income.

Any American could be at risk of losing health insurance coverage—when they lose a job, when they develop a serious health problem that leaves them unable to work, when they become widowed or divorced, when they reach their 19th birthday and lose eligibility under a parent's policy or Medicaid, or when they or their employer can no longer afford to pay their share of the health insurance premium. But certain groups have typically been most at risk: low- and middle-wage workers, who represent the bottom 60

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[5] J. M. Kingsdale, *Executive Director's Monthly Message*, The Massachusetts Commonwealth Connector, Aug. 25, 2008.

[6] The Kaiser Family Foundation/Health Research and Educational Trust, *Employer Health Benefits*, 2007 Annual Survey.

[7] C. DeNavas-Walt, B. Proctor, and J. Smith, *Income, Poverty, and Health Insurance Coverage in the United States: 2007* (US Census Bureau, Aug. 2008).

percent of all wage earners. Over the last decade, the loss of employer-provided health insurance coverage among these workers has been most marked.[8] Also at high risk are employees of small businesses. While 99 percent of firms with 200 or more employees continue to offer health insurance coverage, the corresponding rate for the smallest firms—those with fewer than 10 employees—is far lower at 45 percent.[9] Employees of small businesses, moreover, often face higher premiums and receive fewer benefits.[10]

Only about two of five children and adults in families with incomes placing them below 200 percent of the federal poverty level have employer-sponsored coverage. Not surprisingly, low-income families are more vulnerable than higher-income families to being without health insurance at some point during the year. They also are more likely to have inadequate insurance, when they have it at all. In fact, 72 percent of working-age adults with incomes of less than twice the federal poverty level are either uninsured at some point during the year or are underinsured.[11] Simply put, private markets are not working for low-income adults.

The economic consequences of being uninsured or underinsured are now well documented. A recent study by The Commonwealth Fund found that 79 million Americans have problems paying medical bills or are paying off accumulated medical debt.[12] Adults who experienced medical bill problems face dire financial problems: 29 percent are unable to pay for basic necessities like food, heat, or rent because of their bills; 39 percent use their savings to pay bills; and 30 percent take on credit card debt. Nobody should face bankruptcy or the loss of their home because of a serious illness.

The health consequences are also stark. The uninsured are less likely than the insured to receive preventive care such as immunizations, Pap tests, mammograms, and

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[8] E. Gould, *The Erosion of Employment-Based Insurance: More Working Families Left Uninsured,* EPI Briefing Paper No. 203 (Washington, D.C.: Economic Policy Institute, Nov. 2007).

[9] S. R. Collins, C. White, and J. L. Kriss, *Whither Employer-Based Health Insurance? The Current and Future Role of U.S. Companies in the Provision and Financing of Health Insurance* (New York: The Commonwealth Fund, Sept. 2007).

[10] J. Gabel, R. McDevitt, L. Gandolfo et al., "Generosity and Adjusted Premiums in Job-Based Insurance: Hawaii Is Up, Wyoming Is Down," *Health Affairs*, May/June 2006 25(3):832–43.

[11] The Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008,* The Commonwealth Fund, July 2008.

[12] M. M. Doty, S. R. Collins, S. D. Rustgi, and J. L. Kriss, *Seeing Red: The Growing Burden of Medical Bills and Debt Faced by U.S. Families* (New York: The Commonwealth Fund, Aug. 2008).

colon cancer screening.[13] Uninsured and underinsured adults with chronic conditions are more likely to forgo filling their medications or to skip doses because of costs. As a consequence, they are much more likely to visit an emergency room or be hospitalized for their chronic condition. People without insurance who have life-threatening conditions such as cancer are at very high risk for preventable deaths due to delays in detection plus lack of adequate treatment.[14]

We can no longer afford to ignore the fact that the U.S. is the only industrialized nation that fails to ensure access to essential health care for all its population. In 2007, a staggering two-thirds of all working-age adults—116 million people—were uninsured at some time during the year; underinsured; had a medical bill problem; and/or did not obtain needed health care because of the cost.[15]

**Medicare**

Medicare was created in 1965 because elderly Americans lost their private insurance when they retired. Private insurers were unwilling to take the financial risk of covering a population at risk for significant health problems and substantial health care outlays. With Medicare's broad risk-pooling, the sick are automatically cross-subsidized by the healthy. Administrative costs in Medicare, as well as in the Medicaid program, average less than 2 percent of premiums; large employer plans, meanwhile, expend 5 to 15 percent of premiums, and nongroup plans spend 25 to 40 percent or more on administrative overhead.[16]

Costs in Medicare are also lower than those in private coverage because the Medicare program pays prices for hospitals, physicians, and other health care providers that are lower than prices paid by private insurance. Even so, Medicare continues to

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[13] S. R. Collins, J. L. Kriss, M. M. Doty, and S. D. Rustgi, *Losing Ground: How the Loss of Adequate Health Insurance is Burdening Working Families: Findings from the Commonwealth Fund Biennial Health Insurance Surveys, 2001–2007* (New York: The Commonwealth Fund, Aug. 2008).

[14] C. J. Bradley, D. Neumark, L. M. Shickle, and N. Farrell, *Differences in Breast Cancer Diagnosis and Treatment: Experiences of Insured and Uninsured Patients in a Safety Net Setting,* NBER Working Paper No. 13875, March 2008.

[15] S. R. Collins et al., *Losing Ground: How the Loss of Adequate Health Insurance is Burdening Working Families.*

[16] K. Davis, B. S. Cooper, and R. Capasso, *The Federal Employees Health Benefit Program: A Model for Workers, Not Medicare* (New York: The Commonwealth Fund, Nov. 2003); M. A. Hall, "The Geography of Health Insurance Regulation," *Health Affairs*, March/April 2000 19(2):173–84.

experience high provider participation rates. Surveys show that Medicare beneficiaries are more likely than people who are privately insured to report that they have never encountered a delay in getting a physician appointment for routine care of an illness or injury.[17] Three-fourths of those covered by Medicare and by private insurance report no difficulties in finding a primary care physician, and Medicare beneficiaries are somewhat more likely than those covered by private insurance to report that they did not encounter problems finding a specialist physician.

Compared with health insurance coverage for those under age 65, Medicare beneficiaries report better access to health care services and financial protection from burdensome medical bills. Medicare beneficiaries age 65 and over are less likely to report going without needed care in the past year due to costs.[18] In particular, Medicare beneficiaries are less likely than nonelderly adults covered by employer plans or individual coverage to report access problems related to cost—such as not going to a doctor when needing medical attention; not filling a prescription; skipping a medical test, treatment, or follow-up visit recommended by a doctor; or not seeing a specialist when a doctor thought it was needed. Medicare's cost-sharing, however, can be a deterrent to care for lower-income beneficiaries or those without supplemental coverage.[19]

Originally, Medicare did not cover preventive services. Beginning in the 1990s, however, preventive care was gradually added, and Medicare now covers women's preventive services, pneumococcal pneumonia, and influenza vaccine, among other services. Gaining Medicare coverage greatly improves access to preventive services for those who were uninsured prior to becoming eligible for the program.[20]

In addition to ensuring access to needed care, Medicare's other major goal is to provide financial protection to beneficiaries. Studies have documented that Medicare

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[17] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy,* March 2006, p.85.

[18] K. Davis and S. R. Collins, "Medicare at Forty," *Health Care Financing Review,* Winter 2005–2006:53–62; K. Davis, C. Schoen, M. M. Doty et al., "Medicare vs. Private Insurance: Rhetoric and Reality," *Health Affairs* Web Exclusive, Oct. 9, 2002: W311–324.

[19] T. Rice and K. Y. Matsuoka, "The Impact of Cost-Sharing on Appropriate Utilization and Health Status: A Review of the Literature on Seniors," *Medical Care Research and Review,* Dec. 2004 61(4):415–52.

[20] J. M. McWilliams, A. M. Zaslavsky, E. Meara, and J. Z. Ayanian, "Impact of Medicare Coverage on Basic Clinical Services for Previously Uninsured Adults," *Journal of the American Medical Association,* Aug. 13, 2003 290(6):757–64.

beneficiaries are less likely than adults under age 65 to report problems paying medical bills.[21] Medicare beneficiaries are also less likely than those under 65 to report times when they had difficulty paying or were unable to pay their bills, were contacted by a collection agency concerning outstanding medical bills, or had to change their way of life significantly in order to pay their bills.

Nevertheless, elderly beneficiaries still spend an average of 22 percent of their income on premiums and out-of-pocket health care costs.[22] This is projected to grow to 30 percent by 2025. Few older adults entering retirement have substantial savings from which to draw to meet these expenses.[23]

Medicare beneficiaries are much more likely to rate their insurance as excellent or very good than are those covered by employer plans or individual coverage.[24] Two-thirds (68%) of elderly Medicare beneficiaries rate their insurance as excellent or very good, compared with 44 percent of those with employer coverage, 41 percent of those with individual coverage, and 54 percent of those with Medicaid coverage.

Medicare beneficiaries are also more likely than those under age 65 and covered by private insurance to report being very or somewhat confident that they will get the best medical care available when they need it. Aged Medicare beneficiaries report more choice in where to go for medical care, compared with nonelderly adults.[25]

Beneficiaries' high level of satisfaction with their coverage is also reflected in the interest older Americans attach to qualifying for Medicare coverage. The Commonwealth Fund Survey of Older Adults found that nearly three-fourths of respondents ages 50 to 64 were interested in becoming eligible for Medicare.[26] This was particularly true of older adults with individual coverage and those who were uninsured, with 84 and 94 percent,

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[21] S. R. Collins, K. Davis, C. Schoen, M. M. Doty, S. K. H. How, A. L. Holmgren, *Will You Still Need Me? The Health and Financial Security of Older Americans* (New York: Commonwealth Fund, June 2005).

[22] S. Maxwell, M. Storeygard, and M. Moon, *Modernizing Medicare Cost-Sharing: Policy Options and Impacts on Beneficiary and Program Expenditures* (New York: The Commonwealth Fund, Nov. 2002).

[23] S. R. Collins, M. M. Doty, K. Davis, C. Schoen, A. L. Holmgren, and A. Ho, *The Affordability Crisis in U.S. Health Care: Findings from the Commonwealth Fund Biennial Health Insurance Survey* (New York: The Commonwealth Fund, March 2004).

[24] K. Davis and S. R. Collins, "Medicare at Forty," *Health Care Financing Review*, Winter 2005–2006 27(2):53–62; K. Davis, C. Schoen, M. M. Doty et al., "Medicare vs. Private Insurance: Rhetoric and Reality," *Health Affairs* Web Exclusive, October 9, 2002: W311–324.

[25] K. Davis and S. R. Collins, "Medicare at Forty."

[26] S. R. Collins et al., *Will You Still Need Me? The Health and Financial Security of Older Americans.*

respectively, indicating interest in becoming eligible. Meanwhile, older adults in lower income groups also reported interest at high rates.

Medicare has often been an innovative leader in provider payment reform. Its DRG (diagnosis-related group) method of hospital payment, introduced in 1983, shortened hospital lengths of stay by 10 percent. Its RBRVS (resource-based relative value schedule) method of physician payment, introduced in 1992, has been widely used by private insurers and during the mid-1990s facilitated the growth of managed care discounted networks. Medicare has had some success with demonstrations of new payment methods, and is launching others (e.g., a newly announced bundled-payment method for acute episodes of care provided by hospitals and physicians).[27]

Both Medicare and private insurers could move much more quickly to offer new methods of payment for patient-centered medical homes, physician group practices, hospital systems that have the capacity to provide transitional care, and integrated delivery systems that are willing to be accountable for the total care of patients and willing and able to assume financial risk for a longer continuum of care.[28]

Medicare, as the largest single payer for health care, could also use its purchasing leverage to require that providers adopt electronic information technology and evidence-based medicine. It has begun a major effort to report publicly quality-of-care information at the provider level, but such initiatives could be accelerated. Medicare could also be granted greater flexibility to translate into payment policy more rapidly the lessons learned from its demonstrations on rewarding providers for excellence.

If initiated early, such reforms could slow the growth in health care costs. A recent report prepared for The Commonwealth Fund Commission on a High Performance Health System analyzed the impact on national health expenditures of various reform options, including those designed to: ensure that the best-possible information is used for health care decision-making; promote health and enhance disease prevention efforts;

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[27] S. Guterman and M. P. Serber, *Enhancing Value in Medicare: Demonstrations and Other Initiatives to Improve the Program* (New York: The Commonwealth Fund, Jan. 2007); J. Reichard, "Medicare Hopes to Bundle Way to Better Hospital Care," *CQ HealthBeat*, May 16, 2008.

[28] K. Davis and S. Guterman, "Rewarding Excellence and Efficiency in Medicare Payments." *Milbank Quarterly*, Sept. 2007 85(3):449–68; K. Davis, "Paying for Episodes of Care and Care Coordination," *New England Journal of Medicine*, March 15, 2007 356(11):1166–68; A. Mutti and C. Lisk, "Moving Toward Bundled Payments Around Hospitalizations," presentation to Medicare Payment Advisory Commission, Washington, D.C., April 9, 2008.

align financial incentives with health quality and efficiency; and correct price signals in health care markets.[29] Based on analysis provided by the Lewin Group, the report estimated that over a 10-year period, multiple years of savings add up to a $1.6 trillion cumulative difference in expenditures below projected trends. A combination of actions, each contributing small percentage changes each year, add up to substantial cumulative effects over time.

**Medicaid and SCHIP**

Medicaid, the nation's safety-net health insurance program, covers more than 50 million people, including 41 percent of all births, nearly two-thirds of nursing home residents, 44 percent of persons with HIV/AIDS, and one of five people with severe disabilities.[30] Without Medicaid, we would have far more than 46 million uninsured.[31] In particular, state expansions of Medicaid and SCHIP eligibility over the last decade have helped offset the declines in private health insurance for children.[32] Reauthorization and adequate funding of SCHIP are essential to covering more of the nation's 8 million uninsured children.

Medicaid eligibility for parents and adults without children, however, varies greatly across states: 14 states cover parents only if their incomes are below 50 percent of poverty, which is approximately equivalent to an annual income of just over $10,000 for a family of four.[33] Thirty-five states set thresholds for parents below the poverty level, while 34 states provide no Medicaid coverage at all for non-disabled adults who do not have children. As a result, in the vast majority of states, an adult working full-time, year-long at minimum wage is ineligible for premium assistance.

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[29] C. Schoen, S. Guterman, A. Shih, J. Lau, S. Kasimow, A. Gauthier, and K. Davis, *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending* (New York: Commonwealth Fund, Dec. 2007).

[30] Kaiser Commission on Medicaid and the Uninsured.

[31] D. Rowland, "Medicaid—Implications for the Health Safety Net," *New England Journal of Medicine*, Oct. 6, 2005, 353(14):1439–41.

[32] J. C. Cantor, C. Schoen, D. Belloff, S. K. H. How, and D. McCarthy, *Aiming Higher: Results from a State Scorecard on Health System Performance* (New York: The Commonwealth Fund, June 2007).

[33] Kaiser Family Foundation, "Income Eligibility Levels for Children's Separate SCHIP Programs, 2006" and "Income Eligibility for Parents applying for Medicaid, 2006," available online at http://www.statehealthfactsonline.org.

Elderly and disabled Medicaid beneficiaries account for one-fourth of Medicaid enrollees but 70 percent of Medicaid medical care outlays. Medicaid provides many needed services for patients with complex medical problems—services that are not typically covered by private plans. For example, 35 percent of Medicaid spending goes for long-term care. Medicaid is also a major source of support for safety-net providers, accounting for 39 percent of the revenues of public hospitals and 37 percent of the revenues of safety-net clinics.[34]

Medicaid has been successful in improving access to care for both low-income adults and children.[35] Compared with uninsured adults, adults covered by Medicaid are much more likely to have a regular source of care, less likely to have postponed seeking care because of the cost, and less likely to report that there was a time when they failed to receive needed care or were unable to afford a prescription drug.[36] Similarly, children covered by Medicaid are more likely to have a usual source of care than uninsured children, more likely to have seen a physician in the last two years, and more likely to have had a dental visit in the last two years.[37]

Medicaid and SCHIP are ideal coverage sources for low-income adults and children, and they have a long history of serving low-income children and adults and people with the most serious health problems. In addition, Medicaid's cost per person covered is lower than per-person costs under private coverage.[38]

SCHIP has been highly successful in reducing the rate of uninsured children and improving care for children, with most states accepting the offer of favorable federal matching to expand coverage for low-income children. States' ability to do so, however, depends on economic conditions and may be subject to retrenchment during downturns. Medicaid programs could be strengthened by adjusting the federal matching rate upward in times of high unemployment, when states undergo serious financial strains.

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[34] Kaiser Commission on Medicaid and the Uninsured, based on *America's Public Hospitals and Health Systems, 2004*, National Association of Public Hospitals and Health Systems, Oct. 2006. KCMU Analysis of 2006 UDS Data from HRSA.

[35] D. Rowland and J. R. Tallon, Jr.,"Medicaid: Lessons Drawn from a Decade," *Health Affairs*, Jan./Feb. 2003 22(1):138–144.

[36] Kaiser Commission on Medicaid and the Uninsured analysis of 2006 NHIS data.

[37] Kaiser Commission on Medicaid and the Uninsured analysis of National Center for Health Statistics, CDC, 2007, and Summary of Health Statistics for U.S. Children: NHIS, 2006.

[38] J. Hadley and J. Holahan, "Is Health Care Spending Higher Under Medicaid or Private Insurance?" *Inquiry*, Winter 2003 40(4):323–42.

States have also led in test-driving promising approaches for meeting the particular needs of their populations. Iowa, for example, has reduced the growth in its Medicaid outlays by 3.8 percent over eight years through primary care case management, which is similar to the patient-centered medical home model.[39] North Carolina has improved care, reduced pediatric hospitalization rates, and saved money in its Medicaid program through Community Care of North Carolina, an enhanced primary care case management system and patient-centered medical home model of care.[40] Vermont is using state-employed nurses to assist physician practices with chronic care management.

States are also investing in electronic medical information capacity to ensure that information travels with patients, provide physicians with decision support to enhance patient outcomes, and reduce the risk of errors and duplication of effort. State governments in Massachusetts, Minnesota, Washington, and Wisconsin are employing value-based purchasing in their state public employee or Medicaid programs and joining with other payers to improve quality, reduce administrative cost, provide financial incentives, and leverage health system change.[41]

Yet, more could be done to share best practices and accelerate the dissemination of these innovative models to other states. States should also have an incentive to learn from each other—to spread innovations in information technology, pay-for-performance, patient-centered medical homes, and chronic care management.

**Public Programs and Private Insurers**

It is important to note that public insurance programs work hand-in-hand with—not to the exclusion of—the private market. While funded by the government, Medicare and Medicaid use private insurers when it is efficient to do so. Both programs purchase services from private managed care plans and make extensive use of private insurers as administrative claims payment agents. By utilizing the private market as appropriate, public programs are able to offer beneficiaries a wide array of options.

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[39] E. T. Momany, S. D. Flach, F. D. Nelson, and P. C. Damiano, "A Cost Analysis of the Iowa Medicaid Primary Care Case Management Program," *Health Research and Educational Trust,* Dec. 2006 41(4 Pt. 1):1357–71.

[40] L. Allen Dobson, presentation to ERISA Industry Committee, Washington, D.C., March 12, 2007.

[41] S. Silow-Carroll and T. Alteras, *Value-Driven Health Care Purchasing: Four States that Are Ahead of the Curve* (New York: The Commonwealth Fund, Aug. 2007).

Public programs lower the cost of private coverage because they enroll everyone who meets statutory age or income criteria, regardless of health status. A study for The Commonwealth Fund found that if the sickest 2 percent were excluded from the nongroup private insurance market, the average cost of coverage would drop by more than 20 percent.[42] Clearly, Medicare and Medicaid help private markets work by covering the elderly, the disabled, special-needs children, people with HIV/AIDS, and those with serious mental illnesses. Expanding public programs to cover the sickest and poorest of the uninsured would help ensure affordable private insurance premiums for many of the remaining uninsured. By reducing bad debt and the burden of charity care, expanding public programs would also enhance the financial stability of rural and inner-city hospitals, academic health centers, community health centers, and other safety-net providers—many of which have experienced an increased uninsured patient load in recent years.

Private employer insurance now covers 160 million working Americans and their families. For the most part, employer coverage works well for healthy working families, whose employers contribute, on average, 75 to 80 percent of the premium. However, coverage has become increasingly unaffordable for small firms that are unable to obtain the same benefits and premiums of larger firms.[43]

For those Americans whose only recourse is the individual insurance market, the availability and affordability of coverage depend heavily on state regulation. Of those seeking coverage in the individual market, about nine of 10 do not buy a plan, because it is difficult or impossible to find a plan that is affordable, because they are turned down, or because they cannot find a plan that meets their needs.[44]

Insurance market reforms—including minimum requirements on insurers to cover everyone, the sick and healthy alike, at the same premium—could ensure the availability of coverage in all states. Without such requirements, insurers have a strong incentive to

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[42] S. A. Glied, *Challenges and Options for Increasing the Number of Americans with Health Insurance* (New York: The Commonwealth Fund, Jan. 2001).

[43] J. Gabel, R. McDevitt, L. Gandolfo et al., "Generosity and Adjusted Premiums in Job-Based Insurance: Hawaii Is Up, Wyoming Is Down," *Health Affairs,* May/June 2006 25(3):832–43.

[44] S. R. Collins, J. L. Kriss, K. Davis, M. M. Doty, and A. L. Holmgren, *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Well-being of American Families* (New York: The Commonwealth Fund, Sept. 2006).

enroll the healthiest people, given the strong skewing in the distribution of health expenditures, with 10 percent of people accounting for 64 percent of outlays.[45]

By organizing a national insurance connector that builds on the experience of Massachusetts, we could expand insurance choices to small businesses and individuals. With more integrated benefits and innovative payment policies, a Medicare-sponsored public plan could also be offered as an option to small businesses and individuals.

**The Road Ahead: Using What Works**

The American health care system falls far short of what is achievable. We spend twice as much per person as any other country, yet the U.S. is the only nation that fails to ensure universal financial access to health care. We are slipping further behind what other countries achieve with their more modest investment in health care. Yet, we have at our disposal solid starting points for health care reform, established bases on which to model the system we seek: Medicare, Medicaid, and SCHIP.

Congress can take steps now to lay the foundation for broader health reform that ensures affordable coverage for all Americans. These include: 1) leveraging Medicare's position as the largest payer for health care to improve health care quality and slow the growth in health care costs; 2) strengthening Medicaid and SCHIP to serve as a base of coverage for all low-income children and adults; 3) reforming individual insurance markets; and 4) making affordable insurance options, including a public insurance option, available to small businesses and individuals through an insurance connector.

Medicare can be a leading force for change in the health care system. Its beneficiaries are highly satisfied with their coverage. It offers a wide choice of providers. It has low administrative costs and, as a major purchaser, has lower provider payment rates than private insurance—making it less expensive than premiums available to small businesses. It can serve as a model for private insurers in public reporting, rewarding quality, requiring evidence-based care, and encouraging use of modern information technology. Reforms to Medicare's payment system can improve the accessibility and coordination of care through patient-centered medical homes, help shape a more

[45] S. H. Zuvekas and J. W. Cohen, "Prescription Drugs and the Changing Concentration of Health Care Expenditures," *Health Affairs*, Jan./Feb. 2007 26(1): 249–57.

organized, high performance health system, and create incentives to prevent avoidable hospitalization. These reforms could slow the growth in health care costs and "bend the curve" in national health expenditure trends.

Medicaid and SCHIP have been successful in improving access to care for both low-income adults and children. Compared with uninsured adults, adults and children covered by Medicaid and SCHIP are more likely to get needed care, including preventive care. Many states have shown that they will act to insure low-income individuals if the federal government provides matching financial assistance. Reauthorization and adequate funding of SCHIP are essential steps to covering many of the nation's 8 million uninsured children.

Making federal matching funds available for coverage of low-income adults could also help reverse the trend toward greater gaps in coverage for working-age adults. Expansions to low-wage working adults could also enhance continuity as workers move across multiple jobs and employers. The federal government could further help states maintain and expand coverage in economic downturns by automatically raising the matching rate in times of high unemployment. States should also have an incentive to learn from each other about innovations and best practices in information technology, pay-for-performance, patient-centered medical homes, and chronic care management.

Insurance market reforms—such as requiring insurers to cover everyone, regardless of health status, at the same premium—could ensure the availability of coverage in all states. A new national insurance connector, building on the experience of Massachusetts, could expand insurance choices to small businesses and individuals. With more integrated benefits and innovative payment policies, a Medicare-sponsored public plan could also be offered as an option to small businesses and individuals.

These are steps that build on what already works. As the nation begins serious consideration of health reform, Medicare, Medicaid, and SCHIP must be seen as building blocks in a system of seamless coverage for America's 46 million uninsured people. A mixed private–public system of universal coverage, with coordination across sources of coverage, could transform both the financing and delivery of health care services. Such a system would build on the best that both private insurance and public programs have to offer and also achieve needed savings and ensure access to essential care for all.

Thank you for this opportunity to participate in today's hearing on health care reform and to address questions of the Committee.

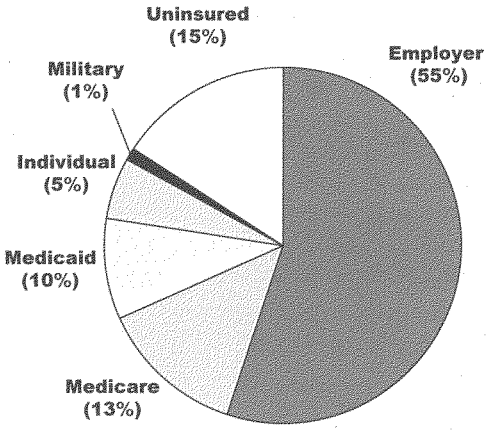

# Using What Works: Medicare, Medicaid and State Children's Health Insurance Program as a Base for Healthcare Reform

**Karen Davis and Cathy Schoen**
**President and Senior Vice President**
**The Commonwealth Fund**
**kd@cmwf.org**

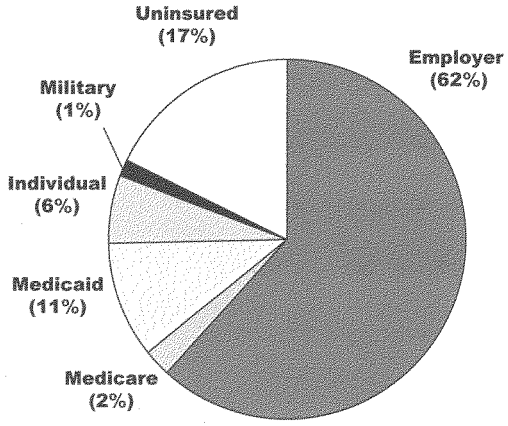
**House Committee on Energy and Commerce**
**Subcommittee on Health**
**September 18, 2008**

# Health Insurance Coverage

## 45.7 Million Uninsured, 2007




**Total population**




**Under-65 population**

Source: Authors' estimates based on S. R. Collins, C. White, and J. L. Kriss, *Whither Employer-Based Health Insurance? The Current and Future Role of U.S. Companies in the Provision and Financing of Health Insurance* (New York: The Commonwealth Fund, Sept. 2007) and analysis of the Current Population Survey, March 2008, by Bisundev Mahato of Columbia University.

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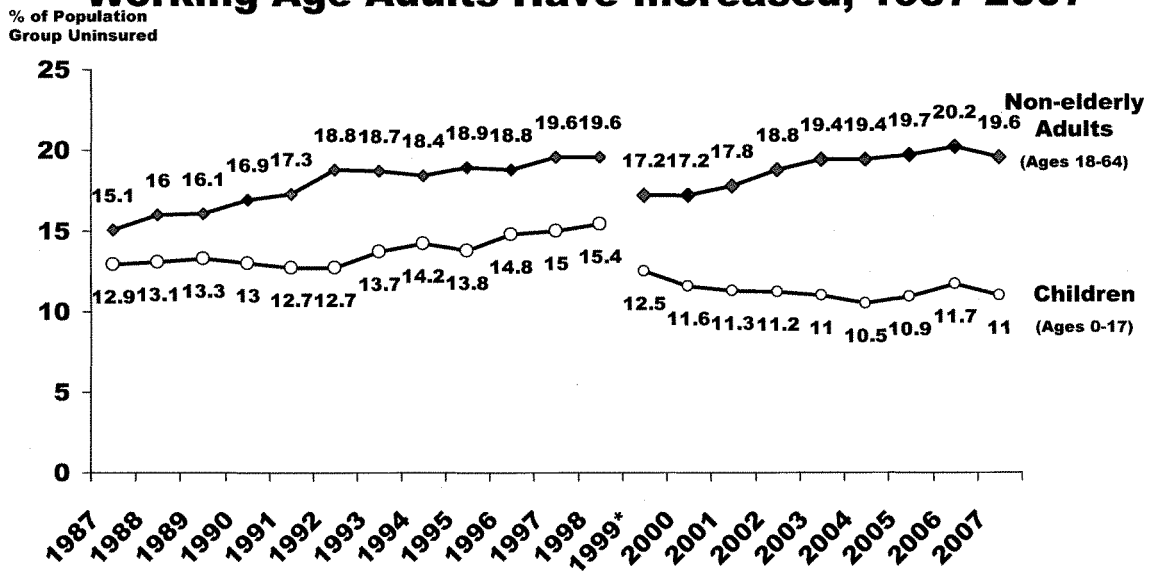
# Percentage of Uninsured Children Has Declined Since Implementation of SCHIP While Uninsured Working-Age Adults Have Increased, 1987-2007




Note: Census methodology changed with the 2000 ASEC, which collected data for 1999. Population controls and implementation of the verification question led to lower estimates of the uninsured.
Source: Calculated from DeNavas-Walt C, Proctor B, and Smith J. "Income, Poverty, and Health Insurance Coverage in the United States: 2007." Washington: Census Bureau, 2008.

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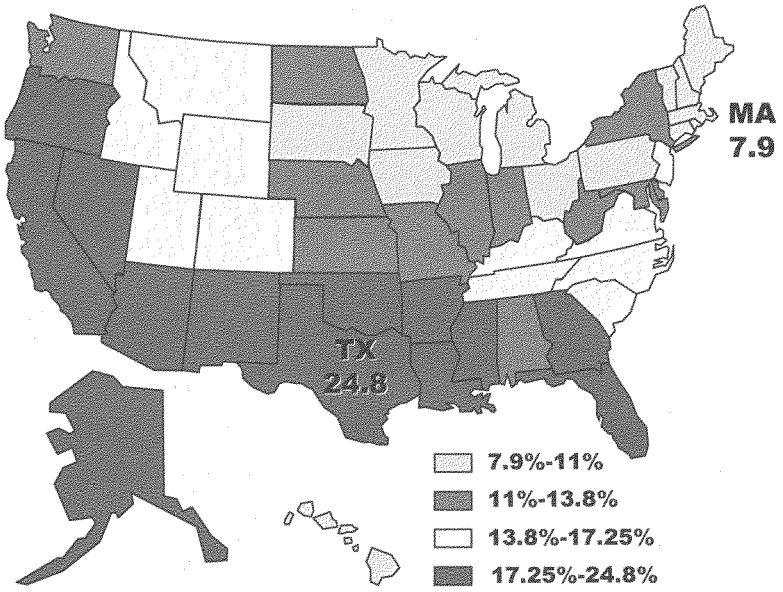
Exhibit 24

# Uninsured Rates, By State, Two-year Average, 2006-07




Source: DeNavas-Walt C, Proctor B, and Smith J. "Income, Poverty, and Health Insurance Coverage in the United States: 2007." Washington: Census Bureau, 2008.

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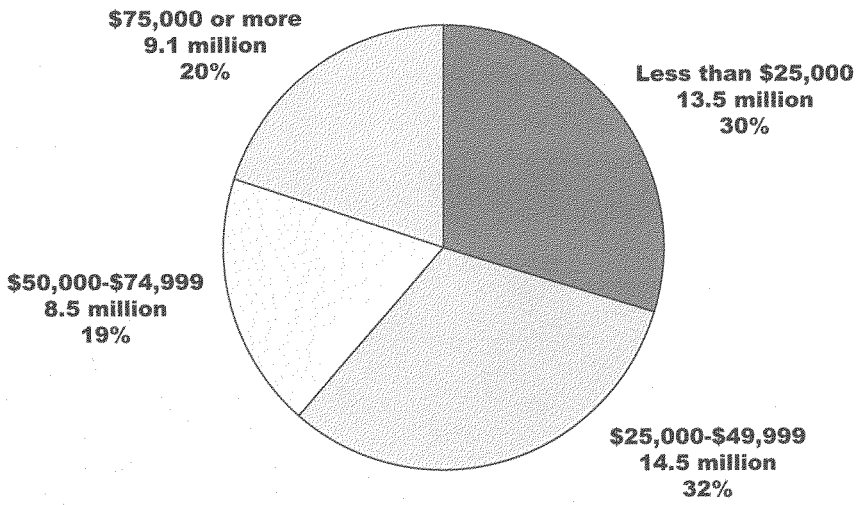
# Uninsured by Household Income, 2007




**Total Uninsured Population = 45.7 Million**

Source: DeNavas-Walt C, Proctor B, and Smith J. "Income, Poverty, and Health Insurance Coverage in the United States: 2007." Washington: Census Bureau, 2008.

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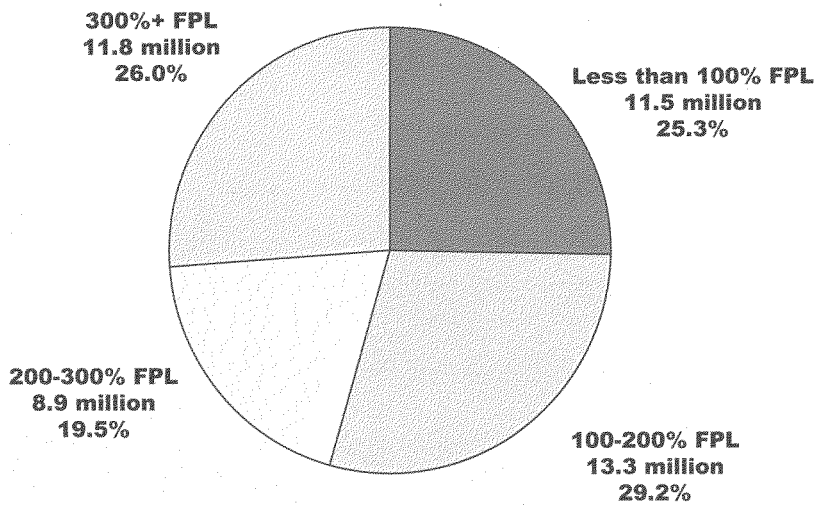
# Uninsured by Federal Poverty Level, 2007




**Total Uninsured Population (Persons in Poverty Universe) = 45.6 Million**

Source: US Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2008.

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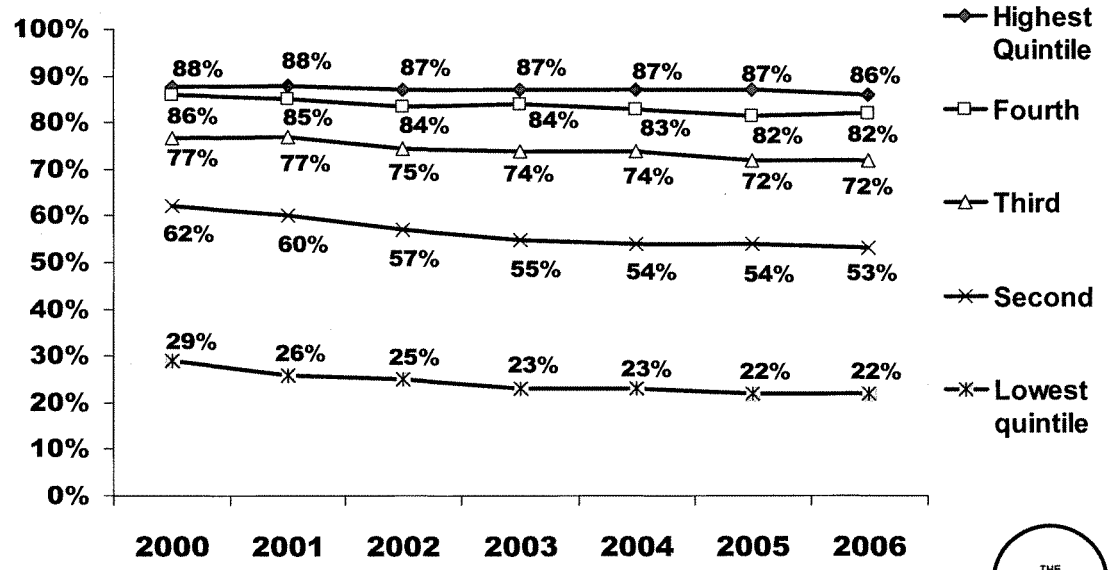
# Employer-Provided Health Insurance, by Income Quintile, 2000–2006

**Percent of population under age 65 with health benefits from employer**




Source: E. Gould, *The Erosion of Employment-Based Insurance: More Working Families Left Uninsured,* EPI Briefing Paper No. 203 (Washington, D.C.: Economic Policy Institute, Nov. 2007).

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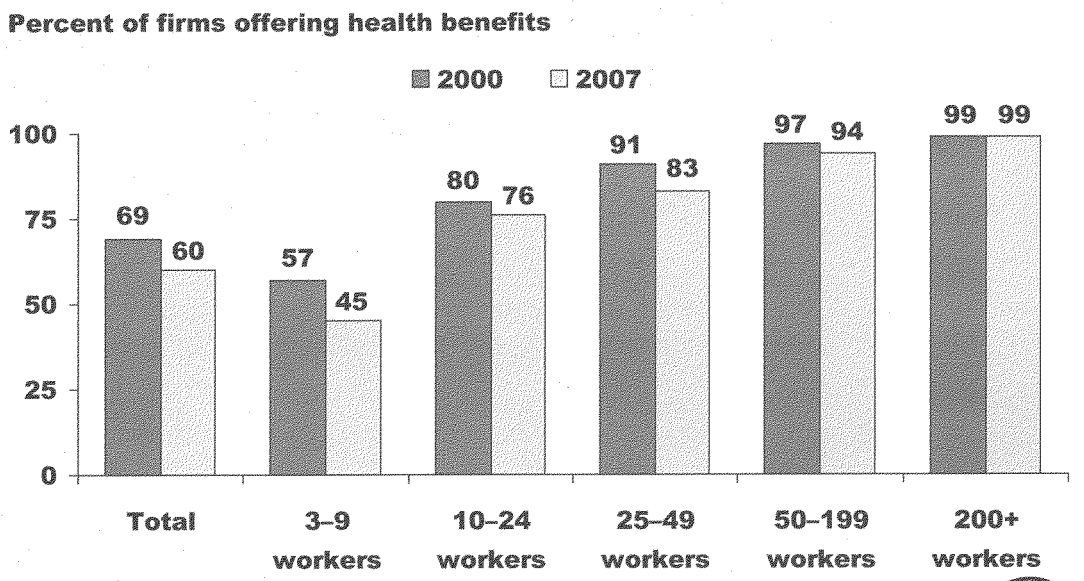
# Employer Coverage Continues to Be Major Source of Coverage for Employees of Larger Firms




Source: S. R. Collins, C. White, and J. L. Kriss, *Whither Employer-Based Health Insurance? The Current and Future Role of U.S. Companies in the Provision and Financing of Health Insurance* (New York: The Commonwealth Fund, Sept. 2007). Data: The Kaiser Family Foundation/Health Research and Educational Trust, *Employer Health Benefits*, 2000 and 2007 Annual Surveys.

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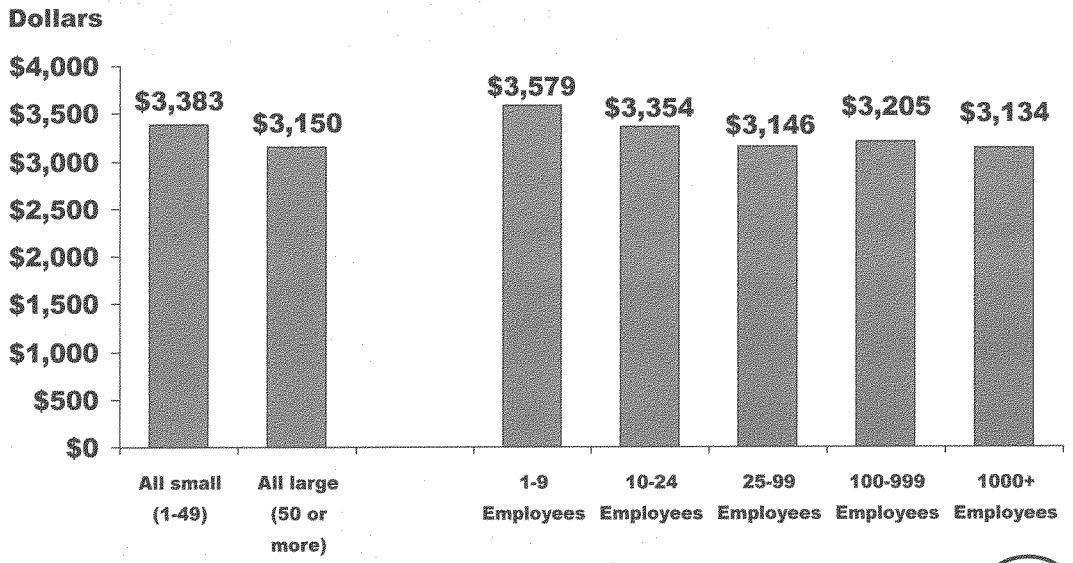
# Single Premium by Size of Firm, Adjusted for Actuarial Value




Source: J. Gabel, R. McDevitt, L. Gandolfo et al., Generosity and Adjusted Premiums in Job-Based Insurance: Hawaii Is Up, Wyoming Is Down, Health Affairs, May/June 2006 25(3):832–43.

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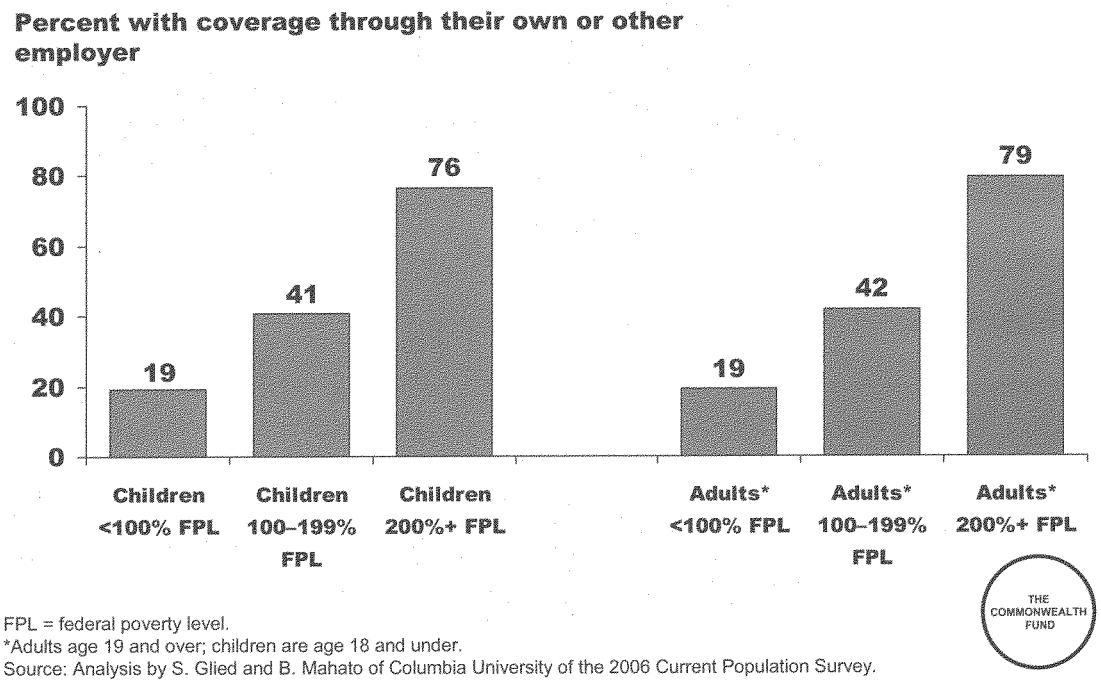
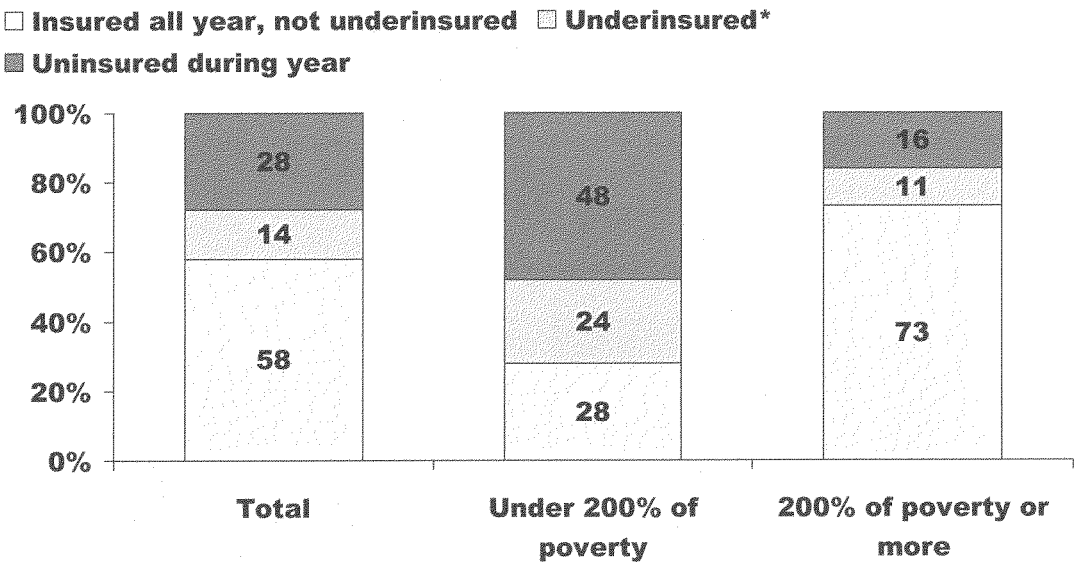
# Percent of Children and Adults With Employer-Sponsored Coverage, by Poverty




FPL = federal poverty level.
*Adults age 19 and over; children are age 18 and under.
Source: Analysis by S. Glied and B. Mahato of Columbia University of the 2006 Current Population Survey.

# Adults Ages 19–64 Who Are Uninsured and Underinsured, By Poverty Status, 2007




*Underinsured defined as insured all year but experienced one of the following: medical expenses equaled 10% or more of income; medical expenses equaled 5% or more of incomes if low-income (<200% of poverty); or deductibles equaled 5% or more of income.

Data: 2007 Commonwealth Fund Biennial Health Insurance Survey

Source: Schoen C, Collins SR, Kriss JL, Doty MM. How many are underinsured? Trends among U.S. adults, 2003 and 2007. Health Aff (Millwood). 2008 Jul-Aug;27(4):w298-309. Epub 2008 Jun 10.

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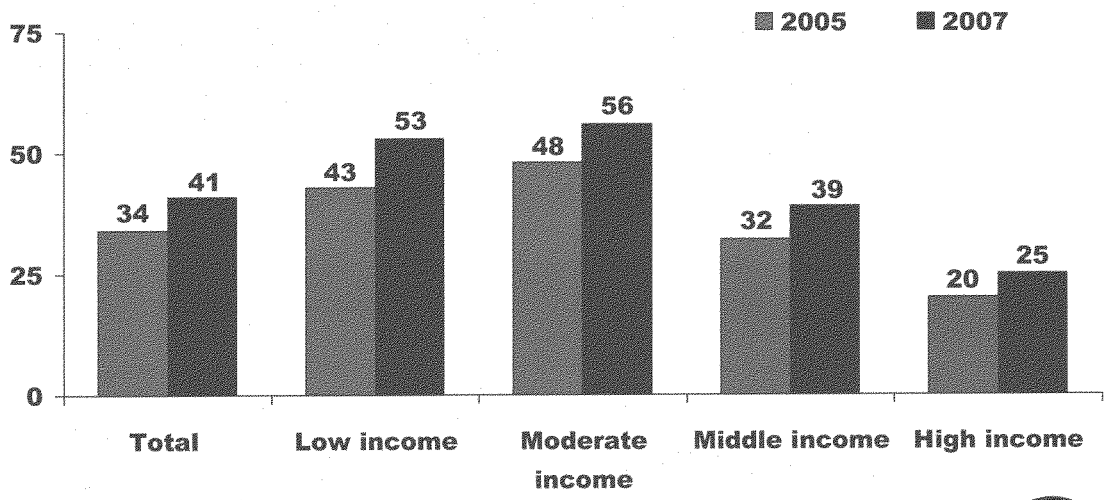
# Problems with Medical Bills or Accrued Medical Debt Increased, 2005–2007

**Percent of adults ages 19–64 with medical bill problems or accrued medical debt**




Note: Income refers to annual income. In 2005 and 2007, low income is <$20,000, moderate income is $20,000–$39,999, middle income is $40,000–$59,999, and high income is $60,000 or more.
Source: The Commonwealth Fund Biennial Health Insurance Surveys (2005 and 2007).

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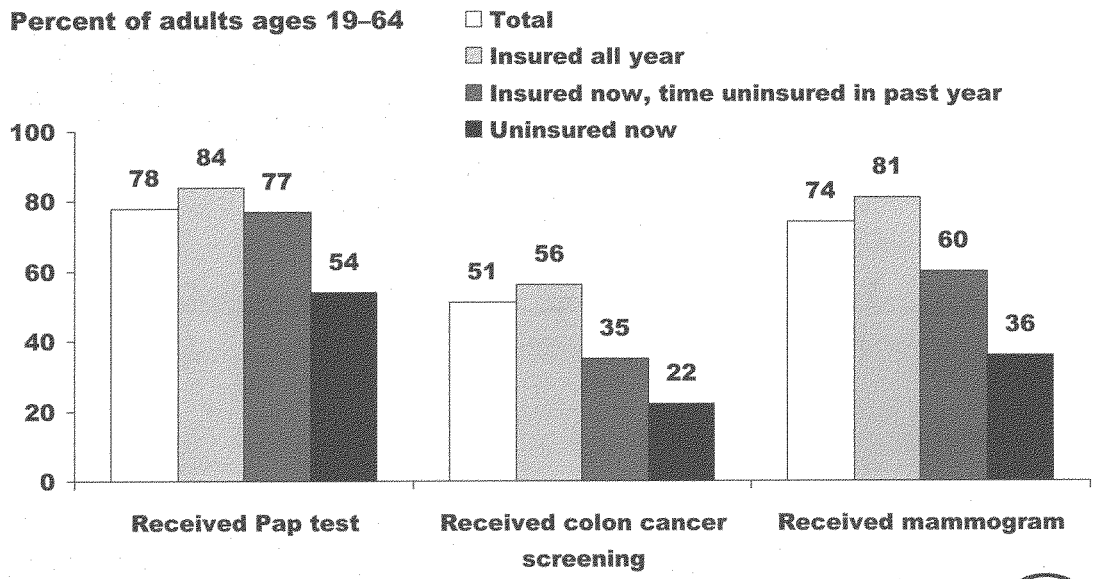
# Uninsured Adults and Adults with Gaps in Coverage Have Lower Rates of Cancer Screening Tests, 2007




Note: Pap test in past year for females ages 19–29, past three years age 30+; colon cancer screening in past five years for adults ages 50–64; and mammogram in past two years for females ages 50–64.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2007).

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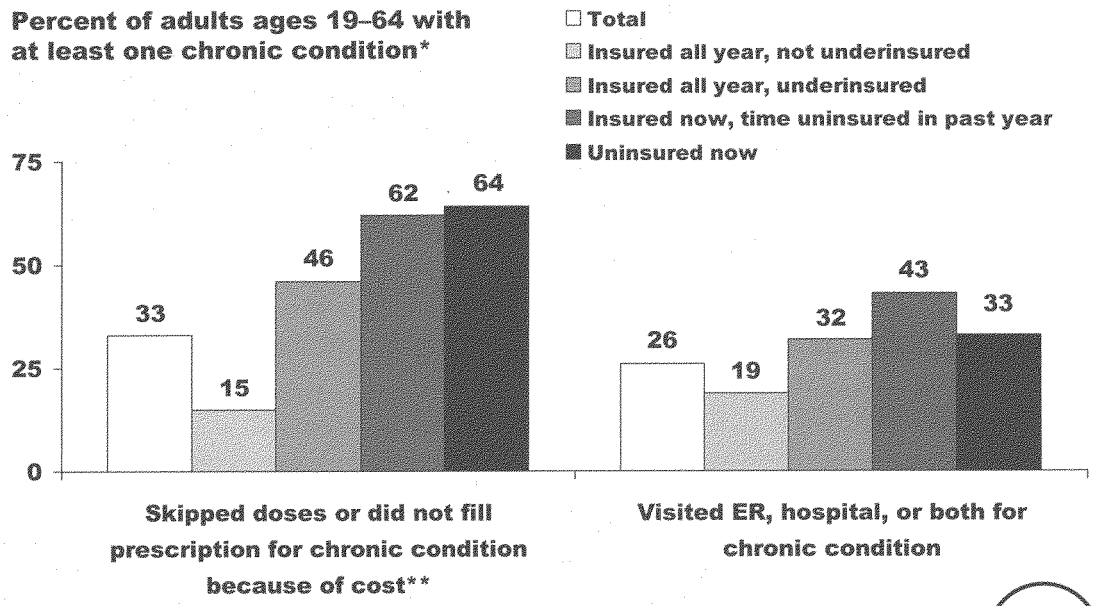
# Uninsured and Underinsured Adults with Chronic Conditions Are More Likely to Visit the ER for Their Conditions




*Hypertension, high blood pressure; heart disease; diabetes; asthma, emphysema, or lung disease.
**Adults with at least one chronic condition who take prescription medications on a regular basis.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2007).

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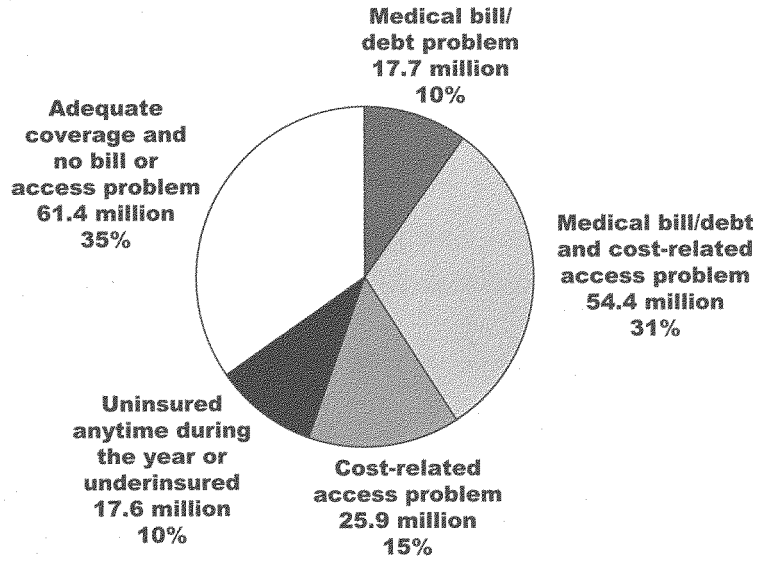
## An Estimated 116 Million Adults Were Uninsured, Underinsured, Reported a Medical Bill Problem, and/or Did Not Access Needed Health Care Because of Cost, 2007




177 million adults, ages 19–64

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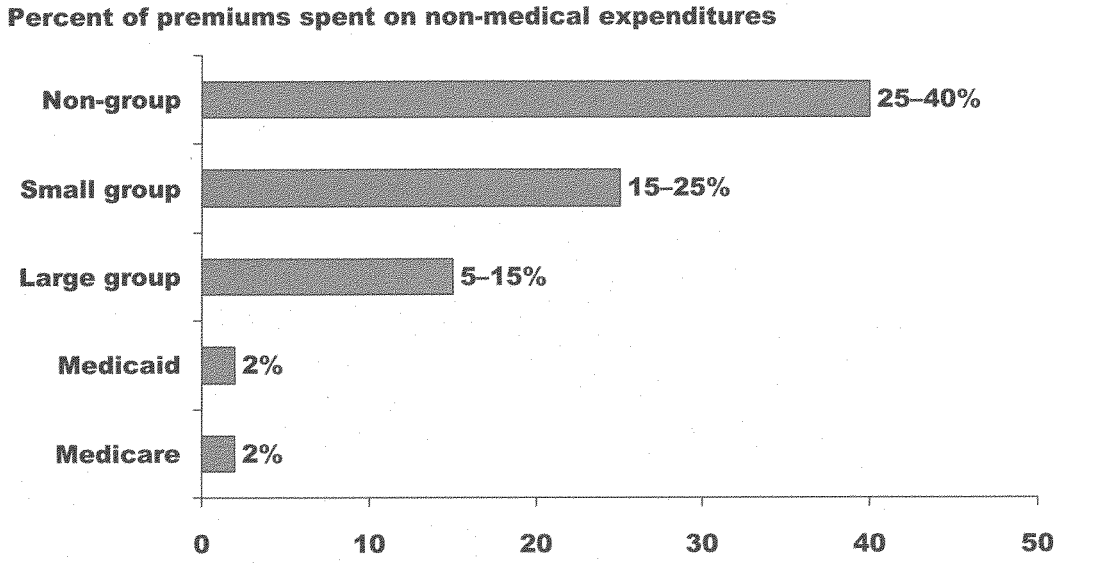
Source: The Commonwealth Fund Biennial Health Insurance Survey (2007).

# Medicare: Working for Elderly and Disabled Americans



# Only Two Percent of Premiums in Medicare and Medicaid Are Spent on Non-Medical Expenditures




Source: K. Davis, B. S. Cooper, and R. Capasso, *The Federal Employees Health Benefit Program: A Model for Workers, Not Medicare* (New York: The Commonwealth Fund, Nov. 2003); M. A. Hall, The geography of health insurance regulation, *Health Affairs*, March/April 2000; 19(2): 173–184;

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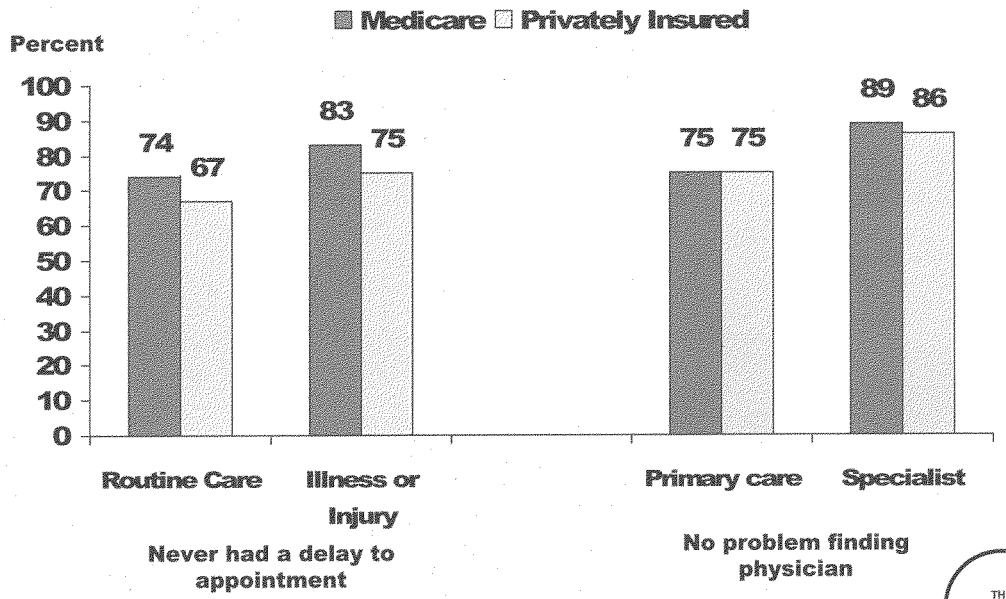
# Access to Physicians for Medicare Beneficiaries and Privately Insured People, 2005

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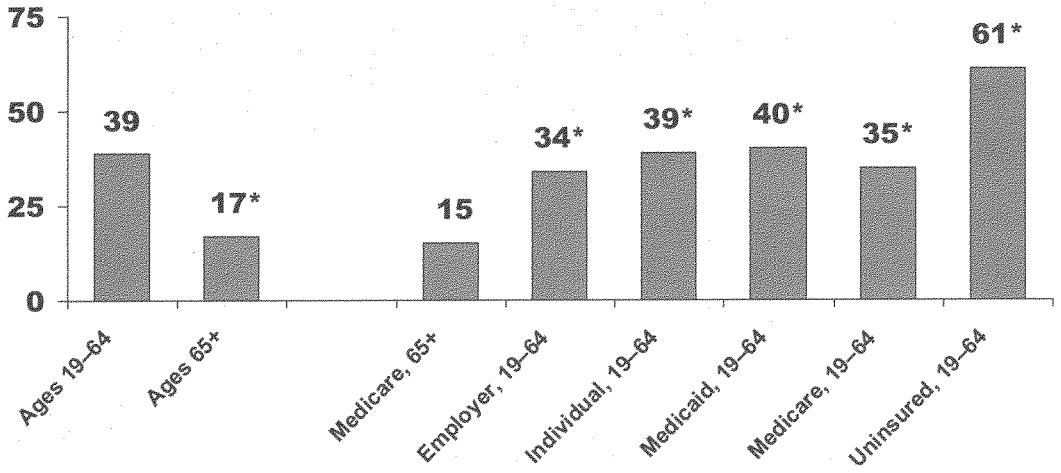
Source: MedPAC Report to the Congress: Medicare Payment Policy, March 2006, p. 85.

# Access Problems Because of Cost

**Percent of adults who had any of four access problems[1] in past year due to cost**




Note: Adjusted percentages based on logistic regression models; age groups controlled for health status and income; insurance status controlled for health status, income, and prescription coverage.

[1]Did not fill a prescription; did not see a specialist when needed; skipped medical test, treatment, or follow-up; did not see doctor when sick.

* Significant difference at $p \leq .01$ or better; referent categories are "ages 19–64" and "Medicare 65+".

Source: K. Davis and S.R. Collins, "Medicare at Forty," *Health Care Financing Review,* Winter 2005–2006 27(2):53–62.

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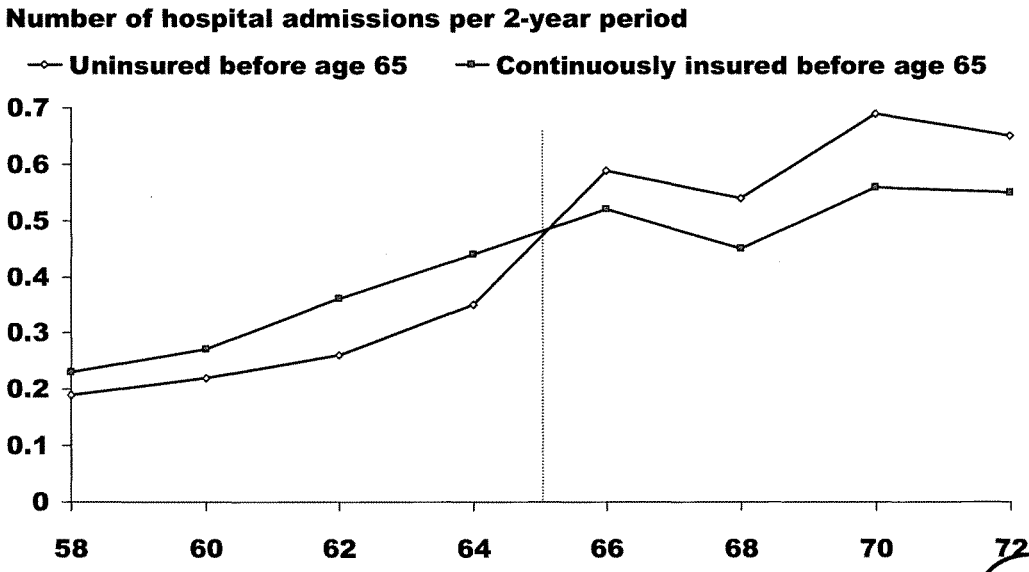
# Previously Uninsured Medicare Beneficiaries With History of Cardiovascular Disease or Diabetes Have Much Higher Self-Reported Hospital Admissions After Entering Medicare Than Previously Insured

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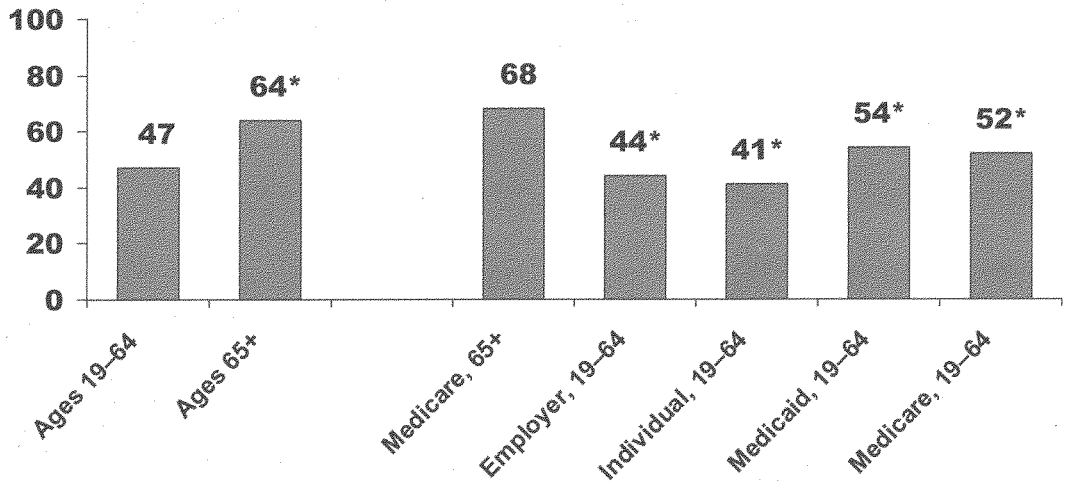
Source: J. M. McWilliams, et al., "Use of Health Services by Previously Uninsured Medicare Beneficiaries," NEJM 357;2, Jul 12 2007.

# Rating of Current Insurance

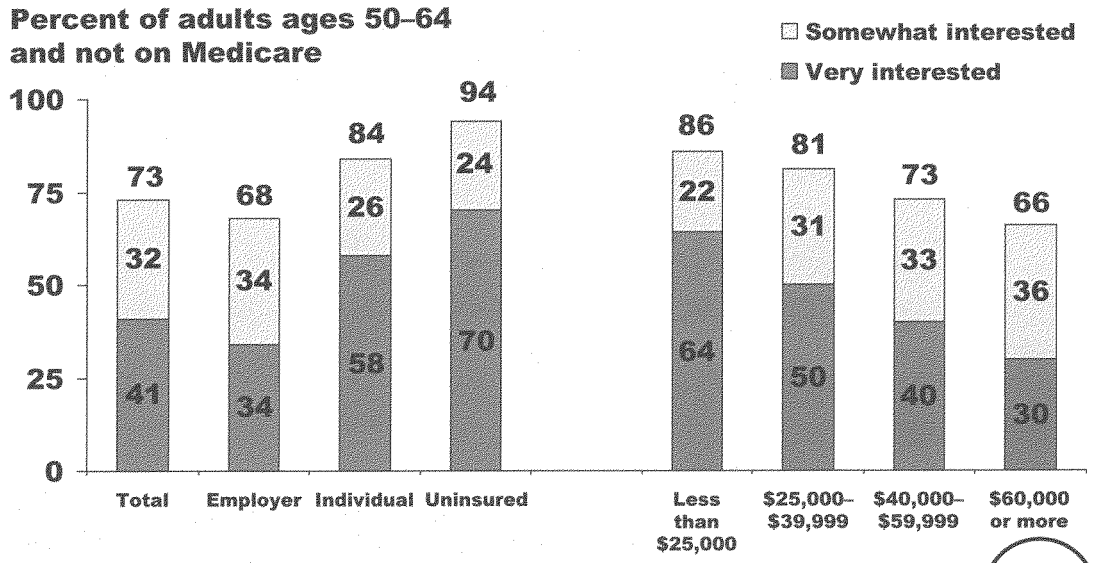
**Percent of adults who rated their current insurance as "excellent" or "very good"**




Note: Adjusted percentages based on logistic regression models; age groups controlled for health status and income; insurance status controlled for health status, income, and prescription coverage.
* Significant difference at p≤.01 or better; referent categories are "ages 19–64" and "Medicare 65+".
Source: K. Davis and S.R. Collins, "Medicare at Forty," *Health Care Financing Review,* Winter 2005-2006 27(2):53-62.

THE COMMONWEALTH FUND

# Percent of Adults Ages 50–64 Who Are Very/Somewhat Interested in Receiving Medicare Before Age 65, by Insurance Status and Income




Source: S. R. Collins, et al., *Will You Still Need Me? The Health and Financial Security of Older Americans: Findings from The Commonwealth Fund Survey of Older Adults*, Commonwealth Fund, June 2005.

# Bending the Curve: Fifteen Options that Achieve Savings Cumulative 10-Year Savings

| | |
|---|---|
| **Producing and Using Better Information** | |
| • Promoting Health Information Technology | -$88 billion |
| • Center for Medical Effectiveness and Health Care Decision-Making | -$368 billion |
| • Patient Shared Decision-Making | -$9 billion |
| **Promoting Health and Disease Prevention** | |
| • Public Health: Reducing Tobacco Use | -$191 billion |
| • Public Health: Reducing Obesity | -$283 billion |
| • Positive Incentives for Health | -$19 billion |
| **Aligning Incentives with Quality and Efficiency** | |
| • Hospital Pay-for-Performance | -$34 billion |
| • Episode-of-Care Payment | -$229 billion |
| • Strengthening Primary Care and Care Coordination | -$194 billion |
| • Limit Federal Tax Exemptions for Premium Contributions | -$131 billion |
| **Correcting Price Signals in the Health Care Market** | |
| • Reset Benchmark Rates for Medicare Advantage Plans | -$50 billion |
| • Competitive Bidding | -$104 billion |
| • Negotiated Prescription Drug Prices | -$43 billion |
| • All-Payer Provider Payment Methods and Rates | -$122 billion |
| • Limit Payment Updates in High-Cost Areas | -$158 billion |

Source: C. Schoen et al., *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending*, Commonwealth Fund, December 2007.

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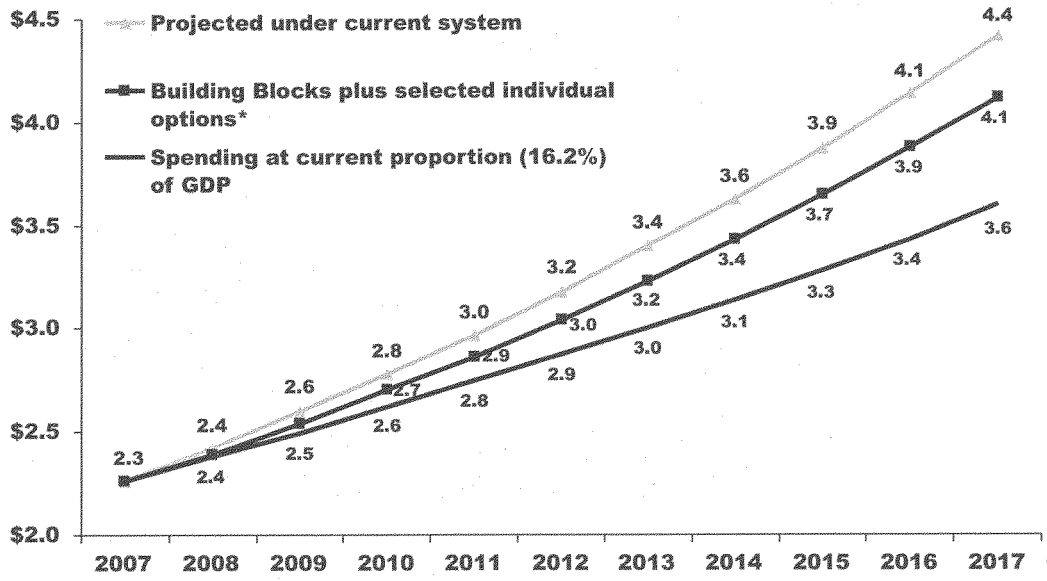
# Total National Health Expenditures, 2008–2017 Projected and Various Scenarios

**Dollars in trillions**




* Selected individual options include improved information, payment reform, and public health.
Source: C. Schoen et al., *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending,* The Commonwealth Fund, December 2007. Data: Lewin Group estimates.

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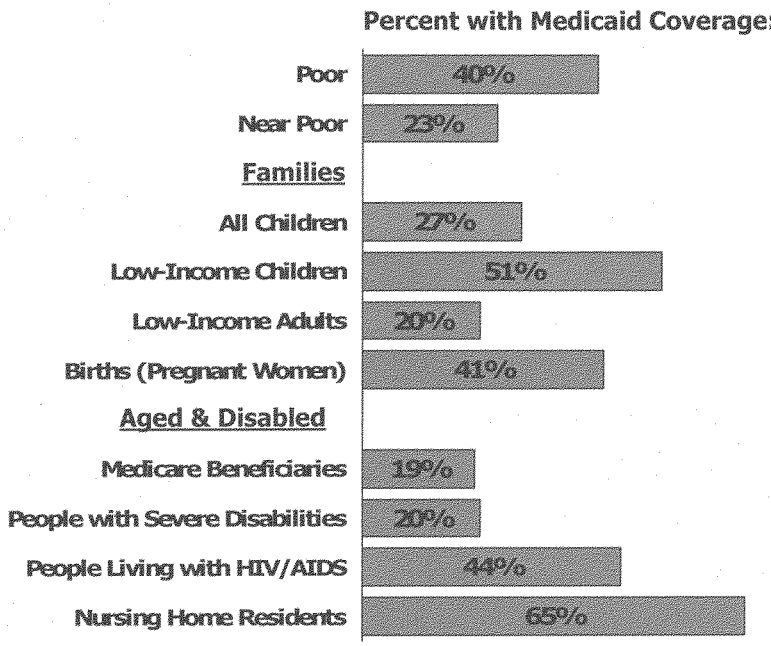
# Medicaid/SCHIP:
# Working for Most at Risk Americans



THE COMMONWEALTH FUND

# Medicaid's Role for Selected Populations

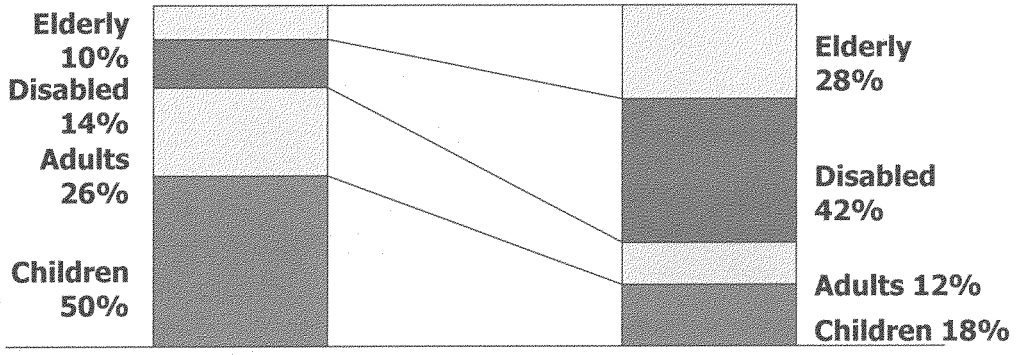



Note: "Poor" is defined as living below the federal poverty level, which was $17,600 for a family of 3 in 2008.
SOURCE: Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, and Urban Institute estimates; Birth data: NGA, MCH Update.

THE KAISER FAMILY FOUNDATION

THE COMMONWEALTH FUND

# Medicaid Enrollees and Expenditures by Enrollment Group, 2005

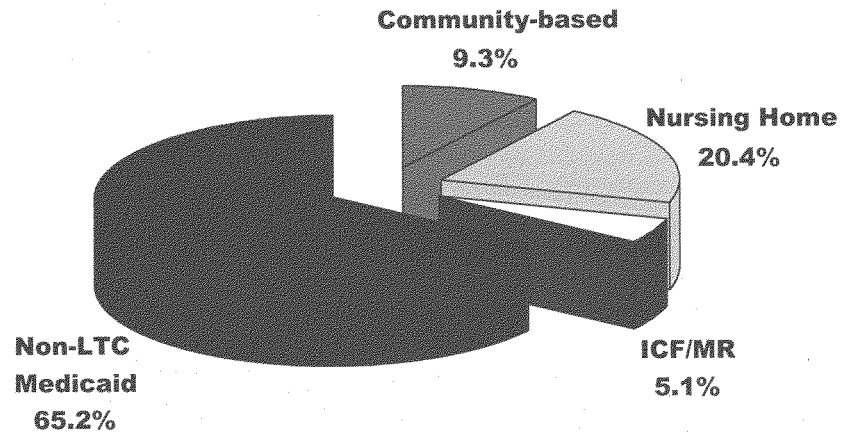



SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on 2005 MSIS data.

THE COMMONWEALTH FUND

KAISER FAMILY FOUNDATION

# Thirty-five Percent of Medicaid Spending Goes to Long-Term Care

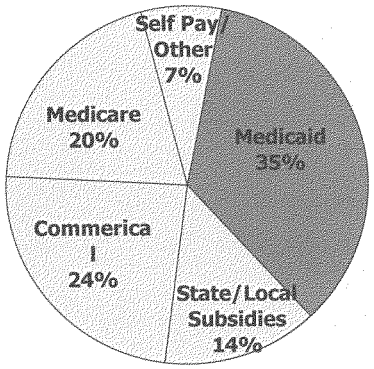



Note: ICF/MR = intermediate care facilities for the mentally retarded
Source: MEDSTAT HCBS

THE COMMONWEALTH FUND

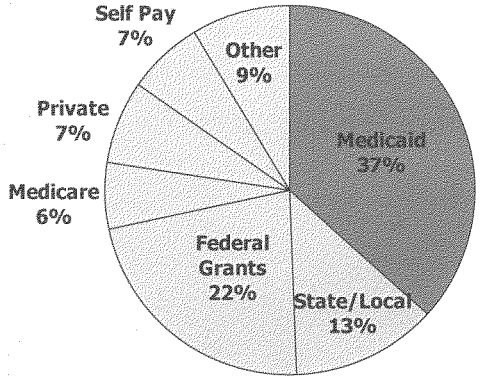
# Medicaid Financing of Safety-Net Providers

## Public Hospital Net Revenues by Payer, 2004




**Total = $29 billion**

## Health Center Revenues by Payer, 2006




**Total = $8.1 billion**

SOURCE: Kaiser Commission on Medicaid and the Uninsured, based on *America's Public Hospitals and Health Systems, 2004*, National Association of Public Hospitals and Health Systems, October 2006. KCMU Analysis of 2006 UDS Data from HRSA.

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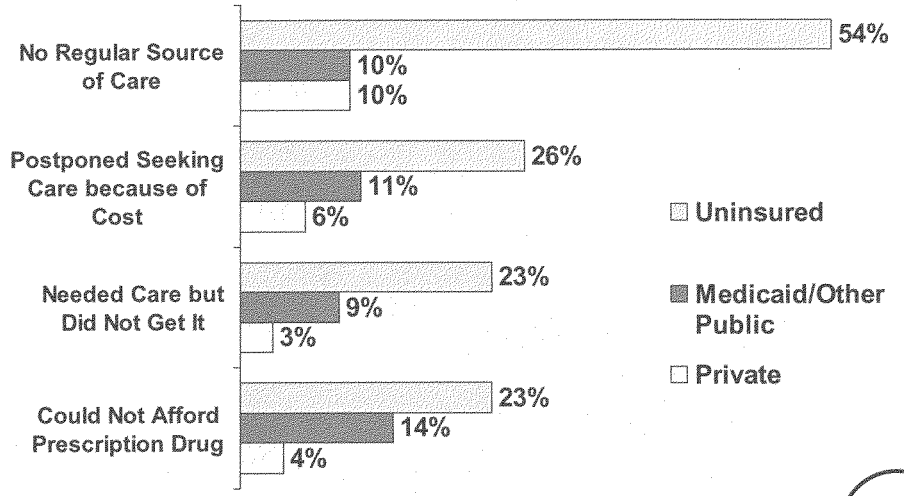
# Barriers to Health Care Among Nonelderly Adults, by Insurance Status, 2006

**Percent of adults (age 19 – 64) reporting in past 12 months:**




NOTE: Respondents who said usual source of care was the emergency room were included among those not having a usual source of care.

SOURCE: Kaiser Commission on Medicaid and the Uninsured analysis of 2006 NHIS data.

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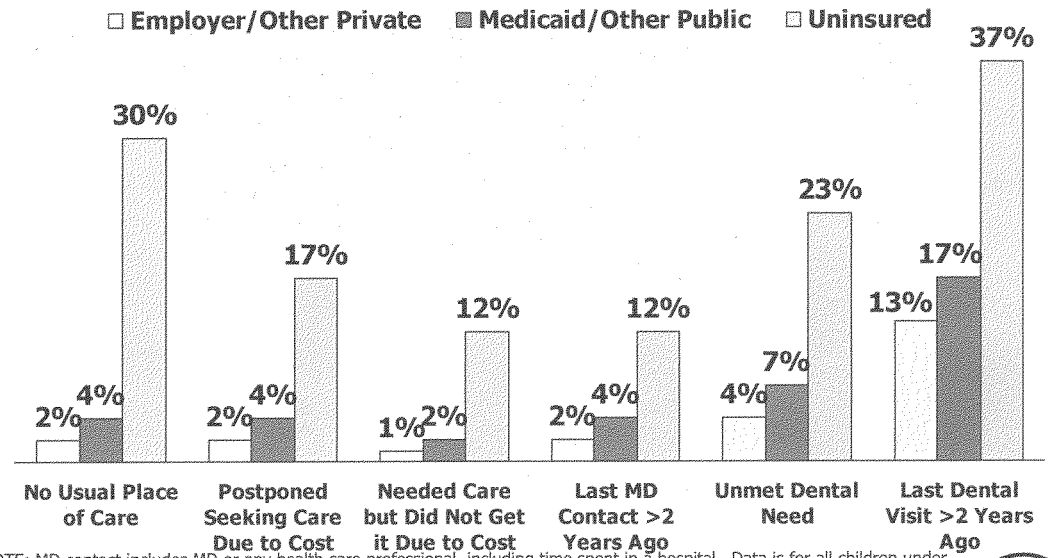
THE HENRY J. KAISER FAMILY FOUNDATION

# Children's Access to Care, by Health Insurance Status, 2006




NOTE: MD contact includes MD or any health care professional, including time spent in a hospital. Data is for all children under age 18, except for dental visit and unmet dental need, which are for children age 2-17. Respondents who said usual source of care was the emergency room were included among those not having a usual source of care. All estimates are age-adjusted.

SOURCE: Kaiser Commission on Medicaid and the Uninsured analysis of National Center for Health Statistics, CDC. 2007. Summary of Health Statistics for U.S. Children: NHIS, 2006.

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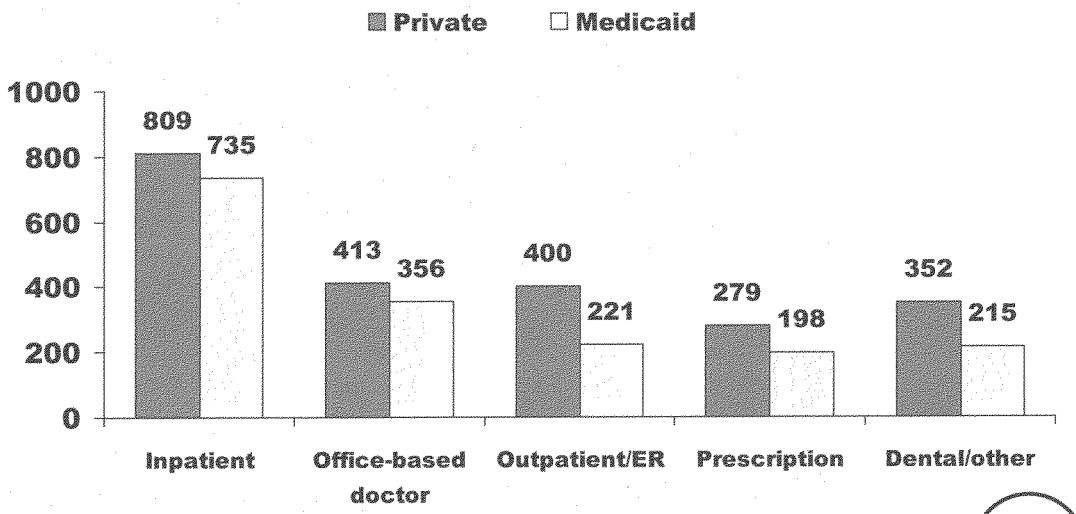
KAISER FAMILY FOUNDATION

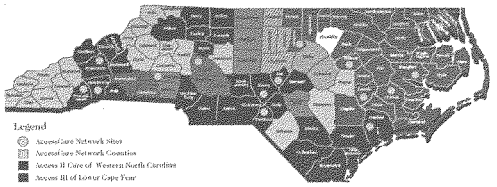
# Medicaid's Spending on Health Services Is Lower Than That of Private Coverage

**Expenditures ($) on health services for people without health limitations in private coverage and Medicaid**




Source: Hadley J., Holahan J., Is health care spending higher under Medicaid or private insurance? *Inquiry*. 2003 Winter;40(4):323-42.

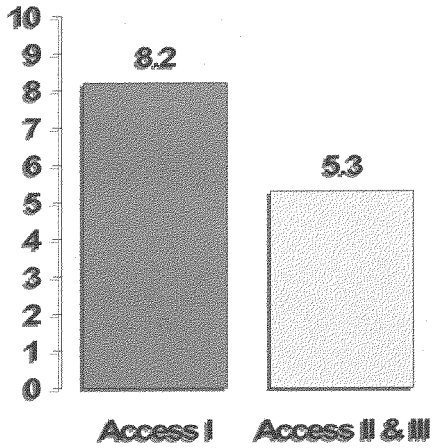
# Community Care of North Carolina: Medical Homes Can Save Health Care Costs




**Asthma Initiative: Pediatric Asthma Hospitalization Rates**

**(April 2000 – December 2002)**

In patient admission rate per 1000 member months




- 14 networks, > 3,200 MDs, >800,000 patients
- $3 PMPM to each network
- Hire case managers/medical management staff
- $2.50 PMPM to each PCP to serve as medical home and participate in disease management
- Care improvement: asthma, diabetes, screening/referral of young children for developmental problems, and more!
- Case management: identify and facilitate management of costly patients
- From July 1, 2003 through June 30, 2006, actuarial studies conducted by Mercer documented that CCNC saved the state over $473 million dollars [September 2007].

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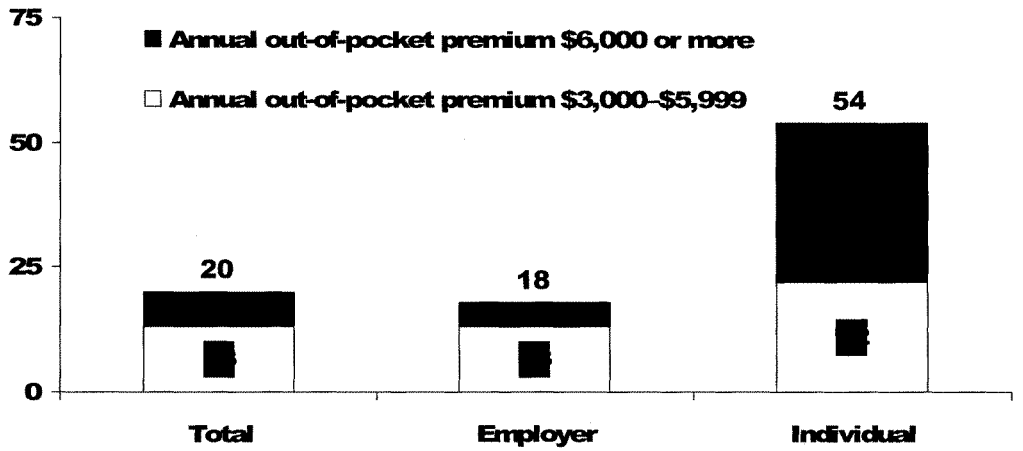
Source: L. A. Dobson, Presentation to ERISA Industry Committee, Washington, DC, Mar. 12, 2007 (Updated 6/13/08)

# Private Insurance: Employer Coverage Works Better Than Individual Markets



# Risk Pooling and Employer Premium Contributions Lower the Cost of Health Benefits for Adults with Employer Coverage Relative to Those with Individual Market Coverage

**Percent of adults ages 19–64 insured all year with private insurance**




Source: S. R. Collins, J. L. Kriss, K. Davis, M. M. Doty, and A. L. Holmgren, Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families, The Commonwealth Fund, September 2006.

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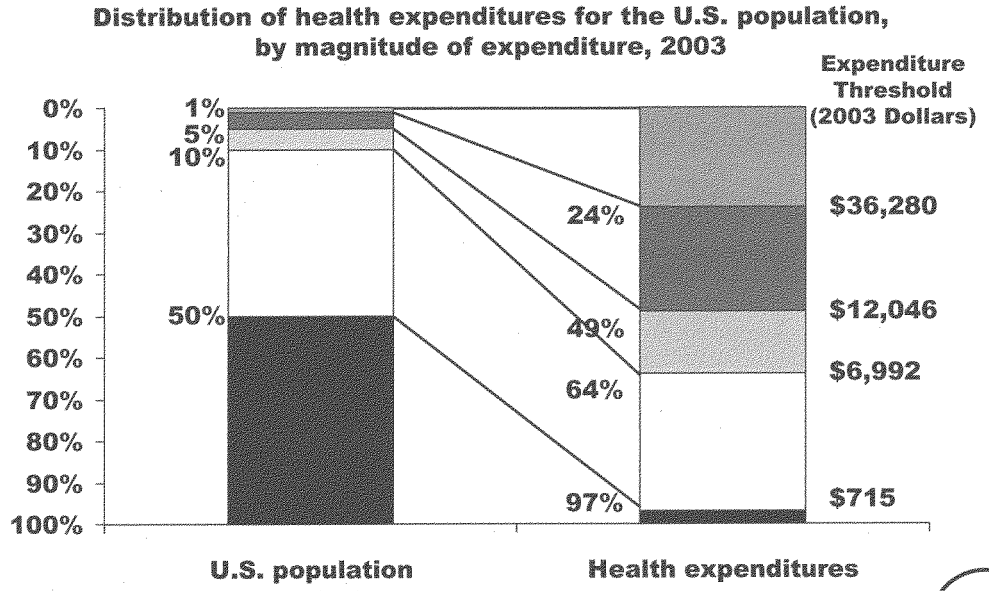
# Individual Market Is Not an Affordable Option for Many People

| Adults ages 19–64 with individual coverage or who thought about or tried to buy it in past 3 years who: | Total | Health Problem | No Health Problem | <200% Poverty | 200%+ Poverty |
|---|---|---|---|---|---|
| Found it very difficult or impossible to find coverage they needed | 34% | 48% | 24% | 43% | 29% |
| Found it very difficult or impossible to find affordable coverage | 58 | 71 | 48 | 72 | 50 |
| Were turned down or charged a higher price because of a pre-existing condition | 21 | 33 | 12 | 26 | 18 |
| Never bought a plan | 89 | 92 | 86 | 93 | 86 |

Source: S. R. Collins, J. L. Kriss, K. Davis, M. M. Doty, and A. L. Holmgren, Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Well-being of American Families, The Commonwealth Fund, Sept 2006.

# Health Care Costs Concentrated in Sick Few
# Sickest 10% Account for 64% of Expenses




Source: S. H. Zuvekas and J. W. Cohen, "Prescription Drugs and the Changing Concentration of Health Care Expenditures," *Health Affairs*, Jan/Feb 2007 26(1): 249–257.

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Mr. PALLONE. Thank you, Dr. Davis.
Mr. Fox.

**STATEMENT OF WILLIAM J. FOX, F.S.A., M.A.A.A., PRINCIPAL AND CONSULTING ACTUARY, MILLIMAN**

Mr. FOX. Hello. I was invited here to talk about the cost shift from Medicare and Medicaid and the impact that has on private insurance premiums. I am from Milliman. We are the largest actuarial employer in the country. We are very focused on our independence and not advocating advice. I will just give you some numbers and not with a specific slant on them.

We have completed cost-shifting studies for Arizona, California, New York, and Washington. We are currently working on a study in Oregon and a nationwide study. So I have a PowerPoint I was told that might come up but I don't know that it will, but anyway, you guys probably have handouts. My presentation is going to cover four main points: what is the cost shift; how large is the cost shift; what is the impact of private insurance premiums and what are the trends; where is this going.

So what is cost shifting? In most areas of the country for the same service, private health insurers pay a lot more than Medicare, which pays more than Medicaid. So in other words, if Medicare and Medicaid paid higher rates, the private payer rates could come down and private insurance premiums, so we should be on the fourth slide now. If Medicare and Medicaid could pay more, the private is that correct payers could pay less and private insurance premiums would be lower with the providers, the hospitals and physicians, still making the same income. So some consider this to be a cost shift to a hidden tax, that effectively employer groups and privately insured people are subsidizing Medicare and Medicaid.

So how large is the cost shift? So to quantify that, I will warn you, this is a sample based on the four States for hospital and three States for physician so the variability from State to State is tremendous and can be very significant. But these are generally pretty indicative of what is happening. On the hospital side, what we are showing here that if a hospital has an average cost of let us say an X-ray, it is $100, then the commercial or private insurance payers are paying about $115.90, and for that same average $100 cost, Medicare is paying about $90 and Medicaid is paying about $86.50, so 13½ percent less there in your chart. On the physician side, there is no fixed cost, but if we take the average reimbursement that physicians get, they are getting about $100 on average let us say for an office visit and they are going to get about $110 from the private payers, about $90 for Medicare and only $76 from Medicaid.

Going on to the next one, so how does that cost shift impact the private insurance premiums? Well, using California as an illustration, we have a total annual premium of $13,800. That is an annual premium for a family, employee, spouse, and children. The cost shift is about 12.2 percent of that, or $1,690. You can see the breakdown in the graph there. The employers pay most that, as Karen just said, 75, 80 percent, $1,234 is paid for by the employer. This is just the portion that is due to the cost shift so this amount would be reduced if there was no cost shift from Medicare/Med-

icaid. And $456 is paid for by the employee. But on top of that, the employee's coinsurance and deductibles, other things are also increased, so $298 comes from the cost sharing for that employee.

So how is the cost shift changing over time? This is a really powerful graph that if you can see it is reducing—what happened in the 1990s with managed care, the cost shift reduced and things came together and now it has been spreading apart. And what happened there in the 1990s was not that Medicare and Medicaid increased their payments, it was that the commercial private payers reduced their payments. There was a lot of competition and the hospitals and physicians managed to lower their costs or lower their reimbursement so that then they made more on Medicaid and Medicare. Now, what has happened since then is either the cost pressures or other things which were not—I am not getting into the solutions just quantifying the numbers, you can understand them, is that since then the costs have been higher than the Medicare and Medicaid increase and its leverage effect to increase that cost shift. This is well illustrated on the next slide, which shows that if you have a 5 percent cost so the hospitals, let us say they have a 5 percent increase in their cost, and Medicare only pays them 3 percent, an increase, and Medicare pays them a 2 percent increase, then the commercial private insurance payers, they have to pay 7.3 percent for that hospital to get the 5 percent. And that is really how the hospitals negotiate. I do a lot of hospital contracting work. They are out there saying here is our bottom line, here is what we are getting, you guys have to pay us the rest, and that is what contributing to the high increase in commercial health insurance and part of the cost there.

And the last slide I have is just to illustrate some of the variance. This is the hospital margins by State. Again, we are mixing different States, different years. We are putting out a national study in the next couple of weeks sponsored by a few large groups but it is important to know that this is very different from market to market, even with a State. I have done some work in Pennsylvania where some parts of Pennsylvania they make money on Medicare, the hospitals do, and some parts they lose a lot of money and so the cost shift and commercial insurance premiums are a lot higher.

Thank you.

[The prepared statement of Mr. Fox follows:]

# Medicare and Medicaid Cost Shifting

Energy and Commerce Sub-Committee on Health
September 18, 2008

Will Fox, FSA, MAAA
Principal & Consulting Actuary

Milliman

# About Milliman

- Milliman is the largest actuarial employer in the country
- We have offices in approximately 30 US cities
- We are independent, non-advocate, professional consultants who work for a wide variety of employers, providers and payers
- Milliman has completed cost shift studies in AZ, CA, NY and WA. We are currently working on OR and a nationwide study.

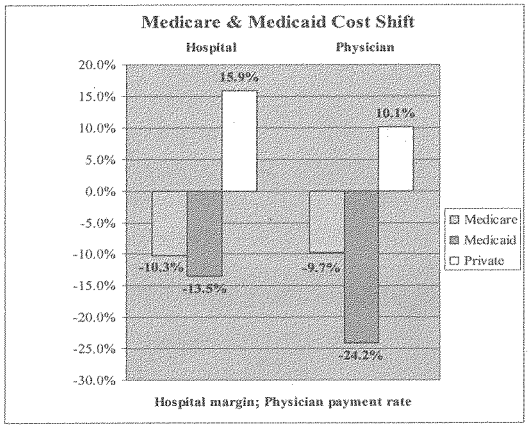
## Overview

1. What is cost shifting?
2. How large is the cost shift?
3. What is the impact on private insurance premiums?
4. What are the trends?

# What is Cost Shifting?

- In most areas of the country, for the same service, private health insurers pay more than Medicare, which pays more than Medicaid
- The payment rate differential can be thought of as a cost shift from Medicare and Medicaid to private payers
- In other words, if Medicare and Medicaid paid higher rates, private payer rates (and private insurance premiums) could be lowered with providers still receiving the same overall reimbursement
- Some consider this cost shift to be a hidden tax since employer groups and other privately insured people are subsidizing Medicare and Medicaid

# How Large is the Cost Shift?

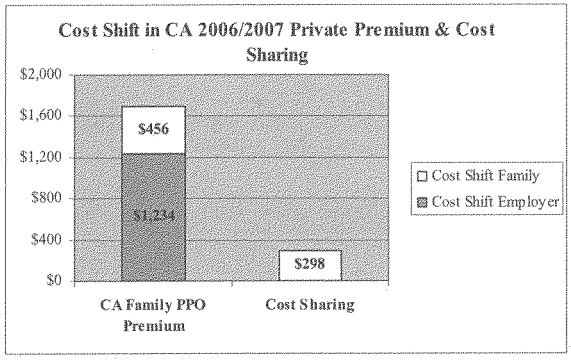



* Hospitals make 15.9% from Private Insurers to make up losses on Medicare and Medicaid

## Notes:

- Varies significantly by geographic area
- These averages are based on 4 states for hospital and 3 states for physician

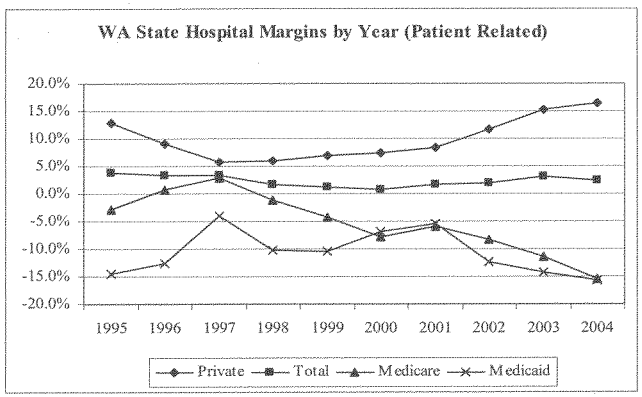
# How Much does Cost Shifting Impact Private Insurance Premiums?




## Notes:

- Varies significantly by geographic area
- Estimate of total annual premium is $13,800
- Cost shift of $1,690 equals 12.2% of total
- Based on family contract: employee, spouse, & child(ren)

# How is the Cost Shift Changing over Time?




Notes:

- Results vary geographically, but we have observed similar patterns in other states

# Why Does the Cost Shift Grow each Year?

**Cost Shift Affects Private Insurance Trends**

| | *Weight* | *Cost Change* | *Payment Change* |
|---|---|---|---|
| Medicare | 35.0% | 5.0% | 3.0% |
| Medicaid | 15.0% | 5.0% | 2.0% |
| Private | 50.0% | 5.0% | **7.3%** |
| Total | 100.0% | 5.0% | 5.0% |

Notes:

- Shortfall on public programs leveraged to private payers

# Illustrative Statewide Variance

**Hospital Margins by State**

| | *2006* *CA* | *2005* *AZ* | *2004* *WA* |
|---|---|---|---|
| Medicare | -16.6% | -10.9% | -15.4% |
| Medicaid | -25.1% | -5.1% | -15.6% |
| Private | 25.7% | 15.4% | 16.4% |
| Average | -0.7% | 5.5% | 2.4% |

Notes:

- Approach by state varies somewhat, but results can be compared across states

# *CALIFORNIA COST SHIFT*

## *HOSPITAL & PHYSICIAN PAYMENT LEVEL COMPARISON BETWEEN MEDICARE, MEDI-CAL, AND COMMERCIAL PAYERS IN CALIFORNIA*

**Presented by:**
**Will Fox, FSA, MAAA**
**John Pickering, FSA, MAAA**

**August 2007**

A MILLIMAN GLOBAL FIRM
Milliman
*Consultants and Actuaries*

At the request of Blue Shield of California (BSC), Milliman, Inc. has prepared this comparison of healthcare provider payment levels between Medicare, Medi-Cal and commercial payers in California. Separate comparisons are presented for hospitals and physicians. We understand that this paper will be shared with hospitals, physicians, employer groups, legislators and others to support a constructive dialogue between all stakeholders regarding provider payment rates paid by public programs.

## EXECUTIVE SUMMARY

Nationwide, attention is increasingly being focused on the provider payment levels of the Medicare and Medicaid programs relative to those of commercial payers. In many areas, commercial health plans pay providers at significantly higher rates than do the public programs. Nationwide, this discrepancy has widened in recent years, as Medicare hospital payments have not kept up with costs and Medicare physician payment levels have remained flat.

The payment rate differential can be thought of as a cost shift from the public programs to the private payers. That is, if Medicare and Medi-Cal paid higher rates, private payer rates could be lower with providers still achieving the same overall reimbursement. As it is, the private payers are subsidizing the cost of Medicare and Medi-Cal, essentially through a hidden tax. The hidden nature of this subsidy makes it difficult to quantify and debate. With this study that quantifies the cost shift in California, we hope to further the public discussion.

This report quantifies the cost shift for the most recent time periods with available data, 2006 for hospitals and 2007 for physicians. For hospital services, we quantify the cost shift historically as well, going back to 2000.

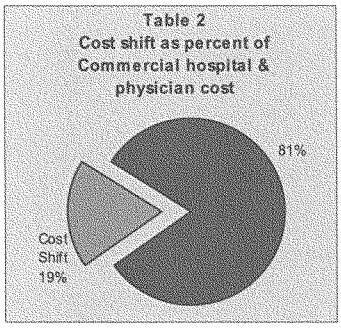
We estimate the annual cost shift in California is approximately $9.2 billion. Table 1 presents our estimates.

**Table 1**
**California Cost Shift**
**in millions**

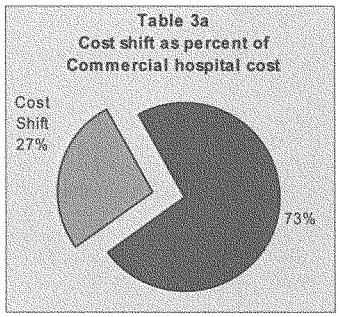
| | *Medicare* | *Medi-Cal* | *Commercial* | *Total* |
|---|---|---|---|---|
| Hospital | ($2,707) | ($2,423) | $5,130 | $0 |
| Physician | ($534) | ($3,508) | $4,042 | $0 |
| Total | ($3,240) | ($5,931) | $9,171 | $0 |

Table 1 shows Medicare was subsidized by $3.2 billion and Medi-Cal was subsidized by $5.9 billion through payment rate differentials. Commercial payers paid $9.2 billion more than they would have if all payers paid equivalent rates. The far right column shows that the cost shift is revenue neutral to providers. That is, we calculate the cost shift by holding total provider reimbursement constant, but redistributing the source of payment.

Table 2 shows that the cost shift of $9.2 billion represents an estimated 19% of the current amount spent by commercial payers on hospital and physician services.



Tables 3a and 3b show that the cost shift figures more prominently in hospital payments than in physician payments, at 27% compared to 14%.



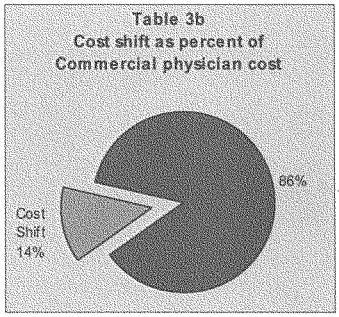




Table 4 translates the cost shift into extra costs paid by employers and employees through premium and cost sharing amounts (deductibles, coinsurance and copays). Table 4 represents the annual amount for a typical family of four and assumes a total annual premium of $13,800.

**Table 4**
**Annual Cost Shift Amount in**
**California Commercial Family Tier Contract**

| | *Premium* | *Cost Sharing* | *Total* |
|---|---|---|---|
| Employer | $1,234 | | $1,234 |
| Employee | $456 | $298 | $754 |
| Total | $1,690 | $298 | $1,988 |

For our illustrative family premium of $13,800, the cost shift adds $1,690 annually, or 14%.[1] Of this, we estimate employers pay $1,234 and subscribers $456 annually. The cost shift also increases member cost sharing by approximately $298 annually.[2]

[1] 14% represents a 19% cost shift on 65% of premium. We assume hospital and physician costs represent 65% of premium, with prescription drugs, health plan administration and margin accounting for the remainder. 14% = (1 / (1 – 19% x 65%)) – 1.

[2] The cost shift affects deductible and coinsurance cost sharing. It would not affect copay cost sharing, although the cost shift impact would then be leveraged into the premium cost. We assume 15% typical cost sharing.

**HOSPITAL PAYMENT LEVEL COMPARISON**

Our hospital findings are based on analysis of State of California Office of Statewide Health Planning and Development (OSHPD) hospital financial data. We reviewed the data for reasonableness, but have not audited or independently verified the data. If the data is inaccurate or incomplete, the results of our analysis may likewise by inaccurate or incomplete.

We restricted the analysis to hospitals that OSHPD defines as "Comparable," which excludes psychiatric, long term care, Kaiser, Shriner and state hospitals. We excluded other hospitals based on our reasonableness review of the data. See the Methodology section for a description of our exclusion criteria.

We define yield as the percent of each dollar billed that a hospital collects. Table 5 presents payment yields by payer in 2006.

**Table 5**
**2006 California Hospital Yields**
**in millions**

| | (A) *Billed* | (B) *Paid* | (C)=B/A *Yield* |
|---|---|---|---|
| Medicare | $77,106 | $16,541 | 21% |
| Medi-Cal | 41,356 | 9,525 | 23% |
| Commercial | 54,001 | 18,958 | 35% |
| Total | $172,463 | $45,023 | 26% |

Table 5 shows that on hospital billed charges of over $77 billion for Medicare business, hospitals actually received a little more than $16.5 billion or 21% of billed. Paid includes amounts paid by Medicare plus patient cost sharing less any bad debt. Similarly, hospitals received 23% of charges for Medi-Cal patients and 35% of charges for commercial patients.

The yields in Table 5 need to be interpreted with caution. Billed charge levels can vary significantly between hospitals. A 20% yield at one hospital with high billed charges could well be a higher actual payment than a 30% yield at another hospital with lower billed charges. The mix of hospitals varies by payer. We developed all of our estimates using hospital specific calculations and present Table 6 to address the hospital mix issue.

Table 6 adjusts for this mix issue by calculating the Medi-Cal and commercial yields relative to Medicare at each hospital, and then composites these ratios across hospitals weighted on Medi-Cal and commercial payments by hospital.

**Table 6**
**2006 California Hospital Yields**

| | *Yield as a Percent of Medicare* |
|---|---|
| Medicare | 100% |
| Medi-Cal | 83% |
| Commercial | 164% |

Table 6 shows that on a hospital mix adjusted basis, the Medi-Cal payment yield was 83% of Medicare and commercial payment yield was 164% of Medicare. In order to ensure the payer/Medicare ratio is meaningful at each hospital, we have restricted Table 6 to include only hospitals with a significant volume of Medicare services. This tends to exclude children's hospitals, for example.

Table 7 presents hospital margins by payer. We used the OSHPD definition of Margin (Gain/Revenue).

**Table 7**
**2006 California Hospital Margins**
**in millions**

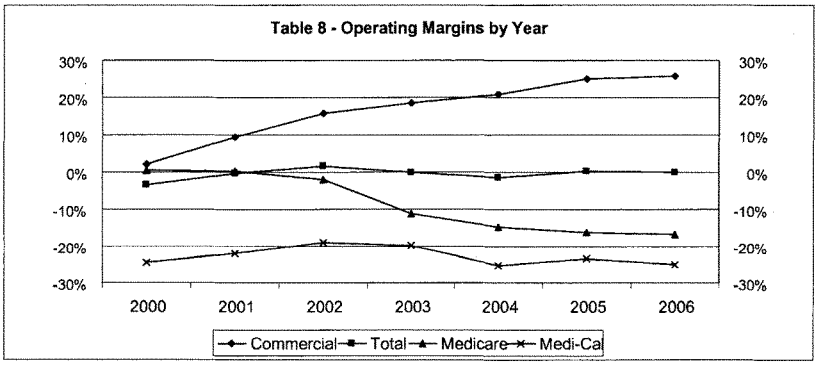
| | (A) *Paid* | (B) *Other Revenue* | (C)=A+B *Total Revenue* | (D) *Operating Expense* | (E)=C+D *Gain* | (F)=E/C *Margin* |
|---|---|---|---|---|---|---|
| Medicare | $16,541 | $614 | $17,155 | ($20,002) | ($2,847) | -16.6% |
| Medi-Cal | 9,525 | 488 | 10,012 | (12,523) | (2,511) | -25.1% |
| Commercial | 18,958 | 576 | 19,534 | (14,506) | 5,028 | 25.7% |
| Subtotal | $45,023 | $1,678 | $46,701 | ($47,031) | ($330) | -0.7% |
| Other Payers | $8,116 | $331 | $8,447 | ($8,048) | $399 | 4.7% |
| Operating Total | $53,139 | $2,009 | $55,148 | ($55,079) | $69 | 0.1% |
| Non-Operating | | | | | $2,431 | |
| Total | | | | | $2,500 | 4.5% |

Table 7 shows that hospitals experienced significant losses on Medicare and Medi-Cal business in 2006, significant gains on commercial payers and moderate gains on other payers, leading to a slight, 0.1% operating margin. With non-operating gains included, the total margin is 4.5%. The "Other Payer" row includes self-pay, CHAMPUS, Workers' Compensation, county indigent programs and other payers. See the Methodology section of this report for more detail on the payer categories.

The Paid values in Table 7 represent payments for patient care. Other Revenue represents non-patient specific revenue. We have allocated Other Revenue by payer in proportion to operating expense. Operating Expense was allocated by payer through the use of a hospital specific cost-to-charge ratio.

For the purpose of this report, we have assumed that the cost-to-charge ratio for each hospital is the same across payers. This is not precise, since a given hospital's cost-to-charge ratio may vary by type of service, and different payers will have different service mixes with the hospital. However, we believe the use of a single cost-to-charge factor by hospital allocates costs reasonably well. The OSHPD data is not detailed enough to support development of payer specific cost-to-charge ratios.

Table 8 presents operating margins by payer by year, back to calendar year 2000.




The graph shows that total hospital operating margins have remained close to 0% from 2000 through 2006. The way in which this 0% total operating margin is achieved, though, has changed significantly. Commercial margin has climbed from 2% in 2000 to 26% in 2006. Medicare margin has declined from 1% in 2000 to -17% in 2006. The Medi-Cal margin has fluctuated somewhat, but remained mostly in the -20% to -30% range.

Table 9 quantifies the percent of analyzed hospitals that lost money on each payer in 2000 and 2006.

**Table 9**
**Hospitals with Losses by LOB**
**CY 2000 and 2006**

| | 2000 | | | 2006 | | |
|---|---|---|---|---|---|---|
| | *Hospitals Analyzed* | *Hospitals with Losses* # | *Hospitals with Losses* % | *Hospitals Analyzed* | *Hospitals with Losses* # | *Hospitals with Losses* % |
| Medicare | 438 | 239 | 55% | 385 | 268 | 70% |
| Medi-Cal | 438 | 328 | 75% | 385 | 304 | 79% |
| Commercial | 438 | 162 | 37% | 385 | 76 | 20% |
| Total | 438 | 226 | 52% | 385 | 167 | 43% |

Table 9 shows that in 2000, 55% of hospitals lost money on Medicare, whereas in 2006, 70% did. Commercial results move in the opposite direction, with 37% of hospitals losing money on commercial payers in 2000 down to 20% in 2006.

These findings demonstrate that the low public payment rate problem is widespread. They also show, though, that some hospitals are able to earn a positive margin on Medicare and Medi-Cal business.

Table 10 presents the hospital cost shift by payer type. We define the cost shift as the additional amount each payer would need to pay in order for the same margin to be achieved from all major payers. For the cost shift calculation, we focus only on the three largest payer segments: Medicare, Medi-Cal and commercial.

**Table 10**
**2006 Califonia Hospital Cost Shift**
**in millions**

| | (A) | (B) | (C) | (D)=C/A | (E)=A-C | (F) |
|---|---|---|---|---|---|---|
| | Actual, with Cost Shift | | *Cost* | *% of* | With Cost Shift Removed | |
| | *Paid* | *Margin* | *Shift* | *Paid* | *Paid* | *Margin* |
| Medicare | $16,541 | -16.6% | ($2,707) | -16.4% | $19,247 | -0.7% |
| Medi-Cal | 9,525 | -25.1% | (2,423) | -25.4% | $11,948 | -0.7% |
| Commercial | 18,958 | 25.7% | 5,130 | 27.1% | $13,828 | -0.7% |
| Total | $45,023 | -0.7% | $0 | 0.0% | $45,023 | -0.7% |

Table 10 shows that in 2006, if Medicare, Medi-Cal and commercial payers were to each supply revenue in the same proportion to their expense, Medicare would have needed to supply an additional $2.7 billion in revenue and Medi-Cal an additional $2.4 billion in revenue. The commercial segment would have needed to supply $5.1 billion less in revenue. If the cost shift were eliminated, hospitals would achieve the same -0.7% operating margin from each payer.

Table 11 presents the cost shift over time.

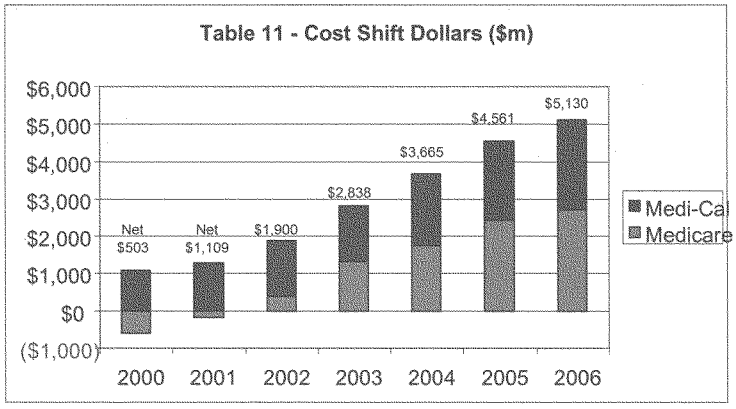



Table 11 shows the cost shift growing from approximately $0.5 billion in 2000 to $5.1 billion in 2006. In 2000 and 2001, Medicare (along with commercial) effectively subsidized Medi-Cal (note the negative cost shift for Medicare in these years). In 2002 and beyond, both Medicare and Medi-Cal were effectively subsidized by commercial payers.

**PHYSICIAN PAYMENT LEVEL COMPARISON**

Our physician findings are based on 2007 fee schedule levels for Medicare, Medi-Cal (schedule effective 8/15/2007) and our estimate of typical commercial 2007 fee schedule levels.

Table 12 compares Medicare, Medi-Cal and commercial physician payment levels as a percent of Medicare rates.

**Table 12**
**2007 California Physician Payment Levels**

| | *Percent of Medicare* |
|---|---|
| Medicare | 100% |
| Medi-Cal | 61% |
| Commercial | 120% |
| Total | 104% |

Table 12 shows that Medi-Cal payment rates are approximately 61% of Medicare and commercial rates are approximately 120% of Medicare. In total across all payers, rates are approximately 104% of Medicare. The cost shift is estimated as the difference between each payer's actual payment level and the overall total of 104% of Medicare.

Commercial payment levels vary by payer and further may vary by geographic area, physician specialty or other factors. Our estimate is intended as an average commercial payment level across all payers, areas, and services.

Table 13 quantifies the physician cost shift.

**Table 13**
**2007 California Physician Cost Shift**
**in millions**

| | (A) | (B) | (C) | (D)=C/A | (E)=A-C | (F) |
|---|---|---|---|---|---|---|
| | Actual, with Cost Shift | | | | With Cost Shift Removed | |
| | *Allowed* | *Pct of Medicare* | *Cost Shift* | *% of Allowed* | *Allowed* | *Pct of Medicare* |
| Medicare | $14,485 | 100% | ($534) | -4% | $15,019 | 104% |
| Med-Cal | 5,060 | 61% | (3,508) | -69% | 8,568 | 104% |
| Commercial | 29,724 | 120% | 4,042 | 14% | 25,683 | 104% |
| Total | $49,269 | 104% | $0 | 0% | $49,269 | 104% |

Table 13 shows that commercial payers subsidized Medicare by $0.5 billion and Medi-Cal by $3.5 billion. In the absence of the subsidy, commercial payers would have paid $4 billion less. The overall magnitude of these values is based on our estimate of total physician revenue by payer type.

**METHODOLOGY**

All values in this report are presented as best estimate point estimates. While we present point estimates to ease interpretation, the reader should realize that, in reality, the values are not precise and should be thought of as center points of ranges of likely values. Different approaches would lead to different results.

*Hospital*

The hospital estimates rely primarily on the quarterly hospital financial data made available on the OSHPD website. We used the quarterly files rather than the annual files in order to present results through 2006. The annual files did not include 2006 data. We recognize that some differences exist between the quarterly and annual reporting. Both reports, though, are self-reported by hospitals.

The OSHPD reporting separates payers into ten categories. Table 14 presents the map between OSHPD categories and the categories in this report.

**Table 14**
**Mapping of OSHPD Payer Types**

| *OSHPD Payer* | *Report Classification* |
|---|---|
| Medicare - Traditional | Medicare |
| Medicare - Managed Care | Medicare |
| Medi-Cal - Traditional | Medi-Cal |
| Medi-Cal - Managed Care | Medi-Cal |
| Other Third Parties - Traditional | Other |
| Other Third Parties - Managed Care | Commercial |
| County Indigent Programs - Traditional | Other |
| County Indigent Programs - Managed Care | Other |
| Other Indigent | Other |
| Other Payers | Other |

We used OSHPD's category "Other Third Parties – Managed Care" for our commercial payer results. The OSHPD definition of the Managed Care category is:

"Managed care patients are patients enrolled in a managed care plan to receive health care from providers on a pre-negotiated or per diem basis, usually involving utilization review

(includes Health Maintenance Organizations (HMO), Health Maintenance Organizations with Point-of-Service option (POS), Preferred Provider Organizations (PPO), Exclusive Provider Organizations (EPO), Exclusive Provider Organizations with Point-of-Service option, etc.)."

The OSHPD data is self reported and some hospitals report Other Third Party data only in the "Traditional" sub-category. "Traditional" is defined as:

"The Other Third Parties – Traditional category includes all other forms of health coverage excluding managed care plans. Examples include Short-Doyle, CHAMPUS, IRCA/SLIAG, California Children's Services, indemnity plans, fee-for-service plans and Workers' Compensation."

We used only the Other Third Parties – Managed Care data for our commercial payer estimates. Since this is self-reported data, we are aware that there is the potential for inaccurate entries. We have outlined our reasonableness review and exclusions below.

Using the OSHPD data, we calculated key financial values for each hospital and then summed across hospitals to arrive at the totals presented in this report. We applied the following methodology to calculate the financial values:

- Paid: Paid is the Net Patient Revenue directly from the OSHPD data. From this, we subtracted the OSHPD reported 'Disproportionate Share Funds Transferred to a Related Public Entity' from the Medi-Cal net patient revenue.
- Other Revenue: Other operating revenue is reported in the OSHPD data. We allocated it by payer in proportion to billed charges.
- Operating Expense: Operating expense is reported in total in the OSHPD data. We allocated it by payer in proportion to billed charges. Operating expenses associated with charity care were spread to all other payers.

The Medicare and Medi-Cal Paid dollars include disproportionate share payments retained by the hospitals. Medi-Cal disproportionate share transfers are excluded. We performed reasonableness checks by hospital on the OSHPD reported data, and excluded hospitals with reported values that are likely incorrect. Our rules for exclusion were:

- Negative or Zero Paid/Billed Ratio
- Negative or Zero Cost/Charge Ratio
- Paid/Billed <0.05
- Paid/Billed >1.00

Hospitals may differ in their reporting of the OSHPD financial data elements, although most are consistent. The formula to calculate the paid/billed ratio is based on typical reporting practices and is consistent with OSHPD instructions. The tests outlined above help us to identify and remove incorrect data.

We have only included hospitals defined by OSHPD as "Comparable." These are general, acute care facilities. OSHPD hospital categories that were excluded are: Kaiser, LTC Emphasis, Psychiatric, Shriner and State Hospitals.

We have not adjusted our estimate of the cost shift for facilities that we excluded from consideration. It is likely that additional cost shift occurs at the excluded hospitals.

*Physician*

In order to estimate the physician cost shift, we needed to estimate both the payment level differences for physician services between Medicare, Medi-Cal, and commercial payers, as well as the overall magnitude of payments from each payer.

To estimate the first component, the relative reimbursement levels, we estimated both the Medi-Cal fee schedule and typical commercial fee schedules as a percent of Medicare.

For Medi-Cal, we compared the 8/15/2007 effective fee schedule to the 1/1/2007 effective Medicare schedule. For each procedure code, we assigned the Medi-Cal and Medicare allowable fees, and summarized results weighted on a Medi-Cal utilization distribution. The percent of Medicare takes into account Medicare GPCI area adjustments, as well as the Medicare site-of-service adjustment.

To estimate typical commercial physician fee levels relative to Medicare, we relied on our market knowledge and proprietary research. Physician fee levels vary between different commercial payers. Our values are intended to reflect a statewide average reimbursement level in 2007, across all professional services and across all commercial payers.

The second component required in order to estimate the cost shift is the overall magnitude of physician payments by payer. We used information from CMS' National Health Care Expenditure Data in order to estimate professional payments by Medicare, Medi-Cal and commercial payers. We applied the relationship between professional and hospital from this data, by payer, and applied it to the hospital payments that we developed based on the OSHPD data.

### CAVEATS AND LIMITATIONS

Milliman is not an advocate for any stakeholders in the California health industry. We are an independent consulting firm that was engaged by BSC to develop a best estimate of the cost shift in California. Using the assumptions presented in this report, we have objectively calculated the estimated cost shift.

This report relies on data and other information from OSHPD. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our review may likewise be inaccurate or incomplete. We have attempted to identify and exclude incorrect data.

Milliman makes no representations or warranties regarding the contents of this report to third parties. Likewise, third parties are instructed that they are to place no reliance upon this report prepared for BSC by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this report must rely upon their own experts in drawing conclusions about cost shifting in California. The estimates included in this report cannot and do not consider every variation from the key assumptions and the effect of variations on the results.

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# *PAYMENT LEVEL COMPARISON BETWEEN PUBLIC PROGRAMS AND COMMERCIAL HEALTH PLANS FOR WASHINGTON STATE HOSPITALS AND PHYSICIANS*

**Presented by:**
**Will Fox, FSA, MAAA**
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**May 2006**

A MILLIMAN GLOBAL FIRM
Milliman
*Consultants and Actuaries*

## *PAYMENT LEVEL COMPARISON BETWEEN PUBLIC PROGRAMS AND COMMERCIAL HEALTH PLANS FOR WASHINGTON STATE HOSPITALS*

At the request of Premera Blue Cross, Milliman, Inc. has prepared this comparison of healthcare provider payment levels between public programs and commercial health plans in Washington State. Separate comparisons are presented for hospitals and physicians. For hospitals, we have analyzed financial statements for fiscal years 1995 through 2004, and quantified the cost shift from Medicare and Medicaid to other payers. For physicians, we have compared current fee schedules and quantified the payment level differences between public and commercial payers. We understand that this paper will be shared with hospitals, physicians, employer groups, legislators and others to support a constructive dialogue between all stakeholders regarding provider payment rates paid by public programs.

### FINDINGS

In recent years, Washington hospitals have incurred increasingly large losses on Medicare and Medicaid business. At the same time, margins on commercial business have increased. This phenomenon can be thought of as a cost shift from the public programs to commercial payers. That is, if Medicare and Medicaid had paid higher hospital rates, commercial payer rates could have been lower with hospitals still achieving the same net patient service operating margins.

Similarly, Medicare and Medicaid fee-for-service physician rates are significantly lower than market rates paid by commercial PPOs in Washington. While publicly available financial statements that would enable quantifying gains and losses by payer type are not available for physician services in total, as they are for hospitals, the payment rate differences suggest a subsidization of public payers by those who pay commercial rates.

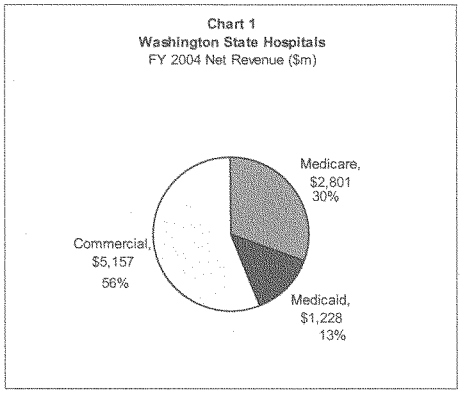
### HOSPITAL PAYMENT LEVEL COMPARISON

Our hospital findings are based on analysis of Washington State hospital financial statements for fiscal years 1995 through 2004, as reported by the Washington State Department of Health. We have reviewed the data for reasonableness, but have not audited or independently verified the data. If the data is inaccurate or incomplete, the results of our analysis may likewise by inaccurate or incomplete.

The Department of Health reported financials are sufficient to separate Medicare, Medicaid, and all other payers into separate categories. The "all other" category is dominated by commercial insurance payers, but also includes payers such as self-pay, Workers' Compensation, and other government programs. Throughout this paper, we refer to the "all other" segment as "Commercial."

In order to focus on payment level differences by payer category, only patient related financial results are included in our analysis. Specifically, non-operating, tax, and other operating revenue and expense are excluded.

Charts 1 and 2 illustrate the cost shift from Medicare and Medicaid to Commercial payers in 2004.



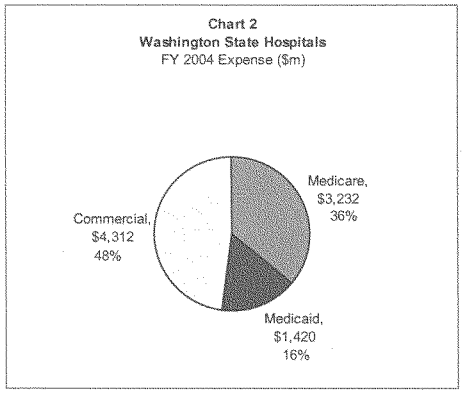




Chart 1 presents net patient service revenue by payer type in fiscal year 2004. Chart 2 presents expense by payer type. Notice that the Commercial segment generated 56% of revenue, but only 48% of expense. On the flip side, 30% of revenue was generated on the Medicare segment, but 36% of expenses were incurred. Likewise, Medicaid accounted for 13% of revenue, but 16% of expenses. If there were no cost shift, each segment's share of

revenue would equal its share of expense. That is, the sizes of the pie pieces would not change between Chart 1 and Chart 2.

Attachment A, at the end of this paper, presents the detailed values underlying all charts presented in this paper.

Chart 3 presents the detail of the fiscal year 2004 cost shift.

**Chart 3**
**Washington State Hospitals**
**Fiscal Year 2004 Cost Shift ($m)**
**Patient Related Services Only**

| | *Net Revenue* | *Expenses* | *Income* | *Margin* | *Cost Shift* | *Revenue without Cost Shift* | *Margin without Cost Shift* |
|---|---|---|---|---|---|---|---|
| Medicare | $2,801 | $3,232 | ($430) | -15.4% | ($510) | $3,312 | 2.4% |
| Medicaid | 1,228 | 1,420 | (192) | -15.6% | (227) | 1,455 | 2.4% |
| Commercial | 5,157 | 4,312 | 845 | 16.4% | 738 | 4,419 | 2.4% |
| Total | $9,186 | $8,964 | $222 | 2.4% | $0 | | |

Chart 3 shows that in 2004 Washington State hospitals, in aggregate, had a -15.4% margin on Medicare business, a -15.6% margin on Medicaid business, and a 16.4% margin on Commercial business, resulting in an overall patient related margin of 2.4%.

In terms of patient related operating income, Medicare resulted in a $430 million loss, Medicaid a $192 million loss, and Commercial an $845 million gain, combining to an overall gain of $222 million.

Chart 3 also shows that if each segment were to supply revenue in proportion to its expense, Medicare would have needed to supply an additional $510 million in revenue, and Medicaid an additional $227 million in revenue. The Commercial segment would have needed to supply $738 million less in revenue. If this cost shift had not occurred, each segment would achieve the overall margin of 2.4%.

Chart 4 presents the fiscal year 2004 cost shift by segment as a percentage of net revenue.

**Chart 4**
**Fiscal Year 2004 Cost Shift Percentages ($m)**

| | *Net Revenue* | *Cost Shift* | *Cost Shift Percentage* |
|---|---|---|---|
| Medicare | $2,801 | ($510) | -18.2% |
| Medicaid | 1,228 | (227) | -18.5% |
| Commercial | 5,157 | 738 | 14.3% |
| Total | $9,186 | $0 | |

Chart 4 can be interpreted to mean that Medicare revenue would need to increase by 18.2% in order to achieve the overall margin of 2.4%. Likewise, Medicaid revenue would need to increase by 18.5%. Commercial revenue could then decrease by 14.3% with hospitals still achieving the aggregate 2.4% margin.

Further, losses on the public programs were widespread among Washington hospitals. Chart 5 presents the percentage of hospitals in Washington State with negative patient related margins by payer segment in 2004.

**Chart 5**
**Hospitals with Negative Patient Related Margins**
**FY 2004**

| | *Hospitals Analyzed* | *Hospitals with Negative Margin* | |
|---|---|---|---|
| | | # | % |
| Medicare | 92 | 74 | 80% |
| Medicaid | 92 | 75 | 82% |
| Commercial | 92 | 25 | 27% |
| Total | 92 | 38 | 41% |

Chart 5 shows that 80% of Washington State hospitals lost money on Medicare and 82% lost money on Medicaid in 2004, compared with 27% losing on the Commercial segment.

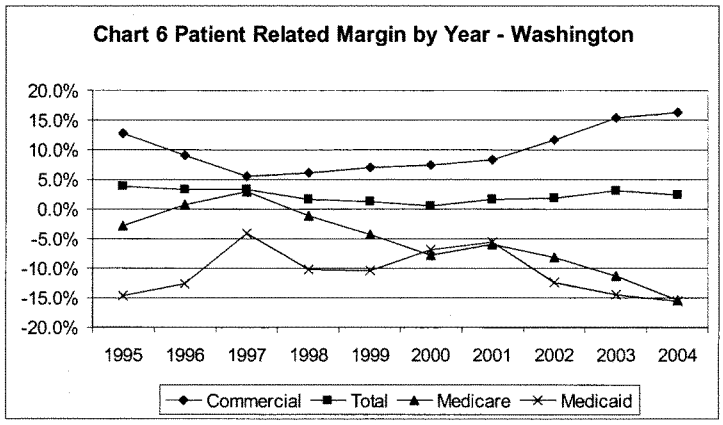
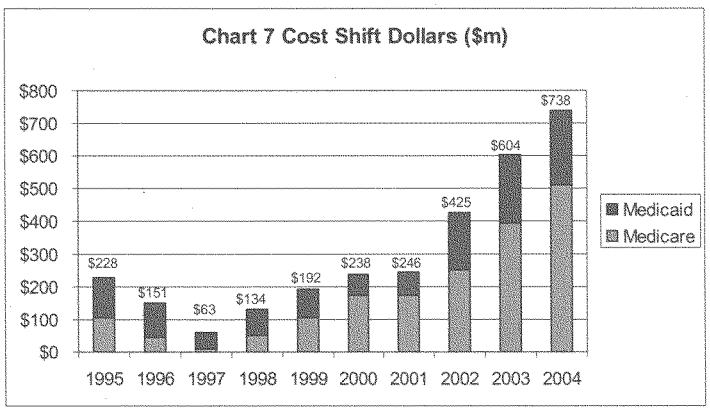


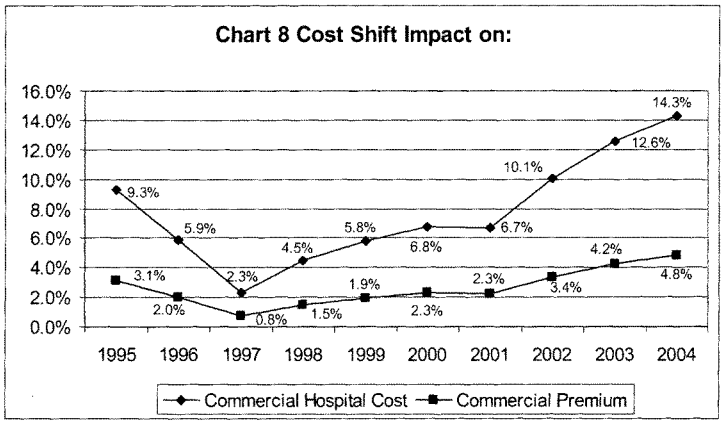

Chart 6 shows that while total patient related margin has remained in the 0% to 4% range from 1995 through 2004, it has been achieved through increasingly large margins on the Commercial segment in order to offset increasingly negative margins on the public segments. Public margins peaked in 1997 and have declined significantly since then. Commercial margins show a reverse mirror image of the public margins, bottoming in 1997 and growing since then.

Chart 7 quantifies in dollar terms the trend in cost shift that was clear in Chart 6.



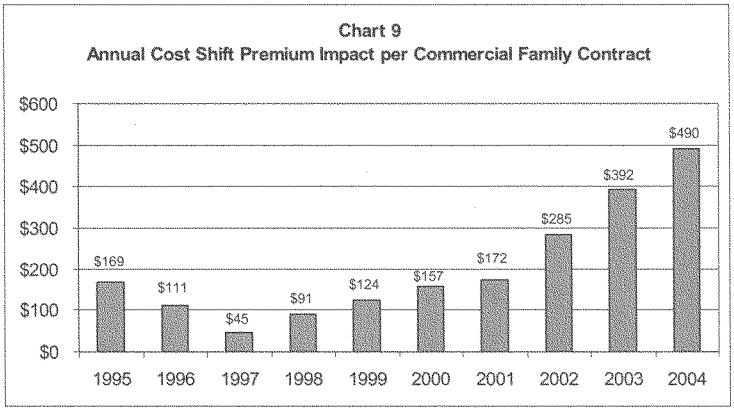

From a $63 million dollar cost shift in 1997, the shift has grown to $738 million in 2004. The cost shift escalated beginning in 2002, with average increases of $164 million per year between 2002 and 2004.

Chart 8 displays the impact of the cost shift on Commercial hospital costs and premium.




In 2004, the cost shift amounted to 14.3% of Commercial hospital cost. With the assumptions that hospital costs represent 40% of medical costs and an 84% loss ratio, the 2004 cost shift amounts to 4.8% of Commercial premium (4.8% = 14.3% x 40% x 84%).

Translating the premium impact into dollars, with typical commercial premium around $850 per family contract per month in 2004, the cost shift amounts to an annual cost of $490 per commercial family contract ($490 = $850 x 4.8% x 12 months). Chart 9 presents the annual premium impact of the cost shift per commercial family contract.



**PHYSICIAN PAYMENT LEVEL COMPARISON**

As with hospitals, commercial health plans in Washington pay considerably higher rates, on average, to physicians than do Medicare or Medicaid. In order to assess physician payment level differences, we have compared physician fee schedules in effect as of March 2006. Chart 10 presents the schedules.

**Chart 10**
**Washington State Physician Fee Schedule Comparison**
**Schedules in Effect March 2006**

| | *Conversion Factor* | *RVU Basis* | *Geographic Adjustment* |
|---|---|---|---|
| Medicare | $37.8975 | 2006 RBRVS | King & Rest of State |
| Medicaid | CF varies by service:<br>$44.99 Maternity<br>$34.56 E&M - Children<br>$24.82 E&M - Adult<br>$22.71 All Other | 2005 RBRVS | Statewide |
| Commercial | Fee schedules vary by payer. Typical schedule:<br>$50.00 - $54.00 | 2005 RBRVS | None (area differences accounted for in conversion factor range) |

Physician allowable fees are typically calculated as a dollar conversion factor multiplied by a relative value unit (RVU) and perhaps further adjusted for geographic area. In practice, there are many variations on this theme. In order to compare fee schedules, each of these components should be considered.

The commercial schedule represents what we believe to be typical commercial payment levels for fee-for-service PPO payers. Commercial payment levels vary by payer, and further may vary by geographic area, physician specialty or other factors. We based this assessment on our market knowledge, information provided by Premera Blue Cross, and publicly available data.

While conversion factors are easy to compare across the schedules listed in Chart 10, the comparison could be misleading because the schedules have different RVU bases and geographic adjustments applied. In order to facilitate an overall comparison, Chart 11 adjusts the conversion factors to a 2005 RBRVS with no geographic adjustment basis. That is, for each schedule, we have calculated an adjustment factor to shift from the actual RVU and geographic basis of the schedule to 2005 RBRVS with no geographic adjustment. Using Medicare King County as an example, we estimate that a $37.90 conversion factor on 2006 RBRVS with a King County geographic adjustment (the actual schedule) would produce the same payment amount, in aggregate, as a $40.19 conversion factor on 2005 RBRVS with no geographic adjustment.

**Chart 11**
**Physician Fee Schedules Expressed on Consistent Basis**
**2005 RBRVS without Geographic Adjustment**

| | *Unadjusted Conversion Factor* | *Adjustment to 2005 RBRVS w/o Geo. Adj.* | *Adjusted Conversion Factor* |
|---|---|---|---|
| Medicare | | | |
| King County | $37.90 | 1.060 | $40.19 |
| Rest of State | $37.90 | 0.984 | $37.28 |
| Medicaid | | | |
| Maternity* | $44.99 | 0.985 | $44.31 |
| E&M - Children | $34.56 | 1.005 | $34.74 |
| E&M - Adult | $24.82 | 1.005 | $24.95 |
| All Other | $22.71 | 1.002 | $22.75 |
| Commercial | | | |
| High Typical | $54.00 | | $54.00 |
| Low Typical | $50.00 | | $50.00 |

*Medicaid has an add-on payment for high risk deliveries of $282.81, which for the most common delivery procedure is worth an additional $6.56 on the unadjusted conversion factor. On the other hand, Medicaid pays the normal delivery rate for cesarean deliveries (which have a higher RVU value), resulting in an unadjusted conversion factor for the most common cesarean delivery procedure of $39.71. We have not made any adjustment for the additional payment or the policy of paying only for a normal delivery.

The adjusted conversion factors are then directly comparable, as all are expressed on the same underlying schedule basis.

Chart 12 presents the commercial adjusted conversion factors as a percentage of Medicare and Medicaid.

**Chart 12**
**Physician Payment Level**
**Commercial as a Percent of:**

| | | Range | | |
|---|---|---|---|---|
| | | *Low* | *to* | *High* |
| Medicare | | | | |
| | King | 124% | | 134% |
| | Rest of State | 134% | | 145% |
| Medicaid | | | | |
| | Maternity | 113% | | 122% |
| | E&M Children | 144% | | 155% |
| | E&M Adult | 200% | | 216% |
| | All Other | 220% | | 237% |

Chart 12 shows that typical commercial payments range from 24% to 45% above Medicare and 13% to 137% above Medicaid.

Chart 13 presents a comparison of payment levels for anesthesiologist services. Anesthesia payments do not follow the same structure as the fee schedules discussed above, so the conversion factors in Chart 13 should not be compared to the earlier conversion factors.

**Chart 13**
**Anesthesia Payment Level**

| | *Anesthesia Conversion Factor* | Commercial as a Percent of: *Low Range* | *to* | *High Range* |
|---|---|---|---|---|
| Medicare - King Co. | $17.99 | 258% | | 281% |
| Medicaid | $20.44 | 227% | | 247% |
| Commercial | $46.50 - $50.50 | | | |

Chart 13 shows that commercial payers pay between 158% to 181% more than Medicare for an equivalent anesthesia service, and between 127% to 147% more than Medicaid.

The commercial conversion factor range in Chart 13 represents our best estimate of typical commercial payment levels; actual payment levels vary by payer. The Medicare conversion factor shown is for King County. The Medicare conversion factor in the rest of the state is lower, at $17.44.

## METHODOLOGY

### *Hospital*

The hospital analyses presented in this paper are based on the Year End Hospital Summary Reports for Washington State hospitals reported by the Washington State Department of Health. We have relied upon this data. We have reviewed the data for reasonableness, and in some cases have made adjustments to the data.

The data adjustments that we made were based on more detailed year-end financials also reported by the Department of Health. In two cases, the reported financials were internally inconsistent, with the inconsistency materially affecting overall results, so the hospital was excluded (excluded only for the year of the inconsistency).

The Department of Health data is sufficient to split billed charges and net patient service revenue between Medicare, Medicaid, and all other. The all other category includes commercial insurance payers, self-pay, Workers' Compensation, and other government programs. Throughout this paper, we refer to the all other category as "Commercial." The reported financial data does not split expenses into these payer segments, however. We allocated expenses to payer segment as described below.

The financials include gross revenue (billed charges) by payer segment. Deductions from gross revenue are reported for contractual rate agreements by payer segment and for charity care/other deductions. We removed the charity care/other deductions from the Commercial segment's billed charges. Total operating expenses were then allocated to each payer segment (Medicare, Medicaid, and Commercial) in proportion to the segment's billed charges. This was performed at the hospital level. In actual practice, the cost to charge ratio will vary by service within a given hospital. Our use of a constant cost to billed charge ratio is an approximation of the actual expense distribution.

The split between Medicare, Medicaid, and Commercial is based on each hospital's reporting of the split. It is likely that some Medicare and Medicaid payments for beneficiaries in health plan managed care programs are reported by hospitals in the Commercial segment, rather than the Medicare or Medicaid segments. To the extent that these managed plans apply payment rates similar to the fee-for-service government programs, this reporting issue serves to lower the cost shift identified in this paper, as the low payment levels for these patients are combined with the higher payment levels for other patients in the Commercial segment. That is, if all payments for Medicare and Medicaid beneficiaries were reported in the Medicare and Medicaid segments, the cost shift would likely be larger than presented here.

The results in this paper present only patient related financial results. Specifically, non-operating, tax, and other operating revenue and expense are not included. As total expenses were available only at the operating and non-operating level, we allocated operating expenses associated with other (non-patient) operating revenue by assuming the same margin between

patient revenue and other revenue. Further, we did not allocate any expenses to tax revenue. All allocations were performed at the hospital specific level.

Group Health Central and Eastside hospitals were excluded from the analyses because they primarily treated only their own members and their summarized financials were not reported in a consistent manner with other hospitals.

***Physician***

The physician fee schedule analyses are based on the 2006 Medicare fee schedule after revision for the Deficit Reduction Act of 2005 (which served to maintain the same conversion factor Medicare applied in 2005, rather than decreasing it), the Washington State Medicaid fee schedule effective 7/1/2005, and our assessment of typical commercial fee schedules as of March 2006.

The Statewide geographic adjustment applied in the Medicaid schedule is equal to 30% of the Medicare King County adjustment and 70% of the Medicare Rest of State adjustment.

The Medicare, Medicaid, and assumed commercial fee schedules all apply the RBRVS site-of-service payment methodology.

In addition to fee schedule levels, claims editing rules applied by payers also affect the total reimbursement received by physicians. We have not attempted to compare or quantify claims edit differences between commercial payers and Medicare or Medicaid.

**Attachment A**
**Washington State Hospitals**
**Patient Related Financial Results**

| | FY 95 | FY 96 | FY 97 | FY 98 | FY 99 | FY 00 | FY 01 | FY 02 | FY 03 | FY 04 |
|---|---|---|---|---|---|---|---|---|---|---|
| Medicare | | | | | | | | | | |
| Billed Charges | $2,248,609,742 | $2,417,358,670 | $2,626,507,446 | $2,781,682,110 | $3,119,753,970 | $3,747,617,801 | $4,302,226,836 | $4,993,869,081 | $5,815,307,513 | $6,580,743,483 |
| Net Patient Revenue | 1,536,438,850 | 1,708,320,696 | 1,838,127,715 | 1,826,849,103 | 1,866,423,886 | 2,039,292,316 | 2,249,605,454 | 2,467,422,519 | 2,653,309,266 | 2,801,192,463 |
| Allocated Expense | 1,578,769,573 | 1,695,904,638 | 1,785,143,197 | 1,848,245,187 | 1,946,956,986 | 2,198,646,760 | 2,381,598,000 | 2,670,261,764 | 2,955,009,940 | 3,231,507,818 |
| Operating Income | (42,330,723) | 12,416,058 | 52,984,518 | (21,396,084) | (80,533,100) | (159,354,444) | (131,992,546) | (202,839,245) | (301,700,674) | (430,315,355) |
| Margin (1) | -2.8% | 0.7% | 2.9% | -1.2% | -4.3% | -7.8% | -5.9% | -8.2% | -11.4% | -15.4% |
| Medicaid | | | | | | | | | | |
| Billed Charges | $1,010,354,460 | $997,751,086 | $1,041,651,054 | $1,092,855,314 | $1,239,434,718 | $1,526,721,157 | $1,791,219,748 | $2,335,673,061 | $2,492,688,331 | $2,782,712,122 |
| Net Patient Revenue | 633,890,955 | 629,871,946 | 701,309,988 | 671,885,554 | 727,242,497 | 869,991,688 | 984,415,659 | 1,184,696,251 | 1,163,504,550 | 1,227,773,606 |
| Allocated Expense | 726,288,304 | 709,469,891 | 729,721,483 | 739,876,995 | 803,099,804 | 929,049,613 | 1,039,273,573 | 1,331,517,814 | 1,330,685,702 | 1,419,726,087 |
| Operating Income | (92,397,349) | (79,597,945) | (28,411,495) | (67,991,441) | (75,857,307) | (59,057,925) | (54,857,914) | (146,821,563) | (167,181,152) | (191,952,481) |
| Margin (1) | -14.6% | -12.6% | -4.1% | -10.1% | -10.4% | -6.8% | -5.6% | -12.4% | -14.4% | -15.6% |
| Commercial | | | | | | | | | | |
| Billed Charges | $3,002,818,266 | $3,276,586,033 | $3,729,107,839 | $4,218,867,148 | $4,947,174,016 | $5,526,701,075 | $6,012,154,396 | $6,950,924,890 | $7,961,867,297 | $8,679,514,563 |
| Net Patient Revenue | 2,443,586,857 | 2,548,908,059 | 2,709,892,133 | 2,990,102,561 | 3,319,610,865 | 3,519,184,802 | 3,659,672,836 | 4,217,157,009 | 4,792,023,366 | 5,156,917,356 |
| Allocated Expense | 2,129,205,709 | 2,317,649,788 | 2,558,262,861 | 2,808,695,623 | 3,087,530,760 | 3,260,567,265 | 3,356,043,279 | 3,722,407,231 | 4,059,317,482 | 4,312,338,637 |
| Operating Income | 314,381,148 | 231,258,271 | 151,629,272 | 181,406,938 | 232,080,105 | 258,617,537 | 303,629,557 | 494,749,778 | 732,705,884 | 844,578,719 |
| Margin (1) | 12.9% | 9.1% | 5.6% | 6.1% | 7.0% | 7.3% | 8.3% | 11.7% | 15.3% | 16.4% |
| Total | | | | | | | | | | |
| Billed Charges | $6,261,782,468 | $6,691,695,789 | $7,397,266,339 | $8,093,404,572 | $9,306,362,704 | $10,801,040,033 | $12,105,600,980 | $14,280,467,032 | $16,269,863,141 | $18,042,970,168 |
| Net Patient Revenue | 4,613,916,662 | 4,887,100,701 | 5,249,329,836 | 5,488,837,218 | 5,913,277,248 | 6,428,468,806 | 6,893,693,949 | 7,869,275,779 | 8,608,837,182 | 9,185,883,425 |
| Allocated Expense | 4,434,263,586 | 4,723,024,317 | 5,073,127,541 | 5,396,817,805 | 5,837,587,550 | 6,388,263,638 | 6,776,914,852 | 7,724,186,809 | 8,345,013,124 | 8,963,572,541 |
| Operating Income | 179,653,076 | 164,076,384 | 176,202,295 | 92,019,413 | 75,689,698 | 40,205,168 | 116,779,097 | 145,088,970 | 263,824,058 | 222,310,884 |
| Margin (1) | 3.9% | 3.4% | 3.4% | 1.7% | 1.3% | 0.6% | 1.7% | 1.8% | 3.1% | 2.4% |
| Cost Shift | | | | | | | | | | |
| From Medicare to Commercial | $106,294,176 | $46,499,138 | $9,017,930 | $52,909,921 | $105,777,190 | $173,191,845 | $173,031,997 | $252,996,697 | $395,122,063 | $510,461,899 |
| From Medicaid to Commercial | 121,822,737 | 104,244,706 | 53,756,531 | 80,606,847 | 86,270,235 | 64,904,990 | 72,766,569 | 171,832,422 | 209,250,217 | 227,163,951 |
| Total | $228,116,913 | $150,743,844 | $62,774,462 | $133,516,768 | $192,047,425 | $238,096,835 | $245,798,566 | $424,829,119 | $604,372,280 | $737,625,849 |
| As a % of Comm. Hospital Cost | 9.3% | 5.9% | 2.3% | 4.5% | 5.8% | 6.8% | 6.7% | 10.1% | 12.6% | 14.3% |
| As a % of Comm. Premium Cost (2) | 3.1% | 2.0% | 0.8% | 1.5% | 1.9% | 2.3% | 2.3% | 3.4% | 4.2% | 4.8% |
| Annual Prem. Cost per Comm. Family (3) | $169 | $111 | $45 | $91 | $124 | $157 | $172 | $285 | $392 | $490 |

Notes
(1) Margins and other values are patient related only. Other operating, tax, and non-operating revenue and expense are excluded.
(2) Assumes hospital cost = 40% of medical cost and an 84% loss ratio
(3) Assumes 2004 premium PMPM of $236 and family contract load of 3.6

Mr. PALLONE. Thank you, Mr. Fox.
Mr. Bachman.

**STATEMENT OF RONALD E. BACHMAN, F.S.A., M.A.A.A., SENIOR FELLOW, CENTER FOR HEALTH TRANSFORMATION**

Mr. BACHMAN. Thank you. My name is Ron Bachman. I am an Actuary and a Senior Fellow at the Center for Health Transformation. Americans know that a solution is needed to the 47 million people who are uninsured. Any solution must include the sickest among us. No one can be left behind. Any system that works only for the young, healthy, and wealthy is a system destined to failure.

According to the Institute of Medicine, 18,000 people die every year because they are uninsured. Uninsured adults have a 25 percent greater rate of dying than adults with insurance. Simply put, insuring all Americans is a moral imperative. Addressing the uninsured is also an economic development opportunity. Uninsured adults have more absences from work, more unscheduled sick days and greater rates of disability. Eight out of 10 uninsureds are in working families. The great job creation machine in this country is small business yet 65 percent with fewer than 10 employees do not even offer health insurance. Many more Americans are only a pink slip away from losing their jobs and their health insurance.

The uninsureds are a symptom of a dysfunctional system. Focusing on the uninsured rather than arguing over general market reforms, I believe, will lead us to new solutions. We have an outdated legal and regulatory environment with unintended consequences that makes little sense to the average citizen. For example, it is illegal for small groups to provide financial rewards to a diabetic following doctor's orders or incent individuals with financial rewards for healthy behaviors such as wellness, prevention, and early intervention. States add a sales tax to every policy sold, amounting to 2 or 3 percent or more of the premiums. These added taxes only make insurance more unaffordable and increase the number of uninsureds. In 24 States, it is illegal for small employers to contribute to the purchase of individual policies through the use of tax advantaged Health Reimbursement Arrangements.

It is generally illegal under federal law for an unemployed worker to use accumulated HSA savings to pay for health insurance premiums. It is illegal under federal law to provide separate prescription drug benefits under high-deductible health plans. It is illegal under federal law for personally contributed but unused Flexible Spending Account funds to accumulate over time. These are multiple account designs with confusing rules and requirements that make no sense to the average citizen.

A collaboration of key stakeholders worked last year to develop recommendations to lower the uninsured in Georgia by one-third, about 500,000 in our State. The collaboration efforts succeeded. On May 7, 2008, Georgia's Governor Sonny Perdue signed into law health insurance reform legislation that allows insurers to develop significantly more affordable products for small companies and individuals. The new laws focus on the uninsured working poor as a first step. This legislation is estimated to bring an annual increase to economic value to Georgia of $1.9 billion.

The key to success was moving beyond the first generation HSA-eligible plans to a new generation of consumer-oriented products. Critics have concerns regarding coverage under HSA-eligible plans. The required upfront deductibles have been a problem for many. With new generation plans, these concerns are substantially moderated and potentially eliminated. The new Georgia law is a market-based individually centered package of reforms that eliminates outdated insurance laws that unintentionally limited the offering of affordable insurance. The new law allows financial dividends to be placed into Health Savings Accounts for engaging in wellness, prevention, and treatment compliance. Rewards and incentives paid into the HSA by insurers can reduce or eliminate the entire deductible otherwise payable by the patient. Affordability is no longer the dollars you take out of your pocket to pay for an insurance premium. Affordability is also achieved through healthy choices and behavior changes.

Georgia eliminated all State and local sales tax on HSA-eligible plans. As an incentive to offer insurance, companies with fewer than 50 employees are granted a $250 tax credit for each employee enrolled in an HSA-eligible plan. For individual insurance buyers, there is a special Georgia income tax deduction for premiums associated with the purchase of an HSA-eligible plan. The new Georgia law makes it legally clear that there is an option for small employers to contribute tax advantaged HRA dollars to employees for the purpose of buying individual portable health insurance and/or paying for health expenses. Soon Georgians will see products at a fraction of their current cost. The old complaint that HSA-eligible plans are simply high-deductible coverage only for the young, healthy, and wealthy is addressed with these new generation products that are allowed under Georgia law.

Georgia is reflective of a much broader change afoot in this country that is unleashing the creative spirit, the entrepreneurial spirit of Americans to solve the uninsured problem. The process has started. The foundation blocks are bipartisan collaboration, support at the federal law, reform at the state level, creative product development, and citizen involvement in their own health and healthcare and empowered financially with information and choices.

The mission is clear: insure all Americans by 2012 in a 21st century intelligent health system. The questions are: who will help, who will hinder, and who will be willing to give power to consumers over their most precious asset, their health. Thank you.

[The prepared statement of Mr. Bachman follows:]

# Engaging American Ingenuity to Solve the Uninsured Problem

My name is Ronald E. Bachman FSA, MAAA. I am an actuary by background and a Sr. Fellow at the Center for Health Transformation. I am a retired partner from PricewaterhouseCoopers with a retirement mission to solve the uninsured problem, improve mental health services, and expand healthcare consumerism. I am on the Board of Directors of Mental Health America of Georgia and the Georgia Free Clinic Network.

This presentation will outline we see as actually happening to unleash the spirit of American ingenuity to solve the uninsured problem. Putting into perspective how big the challenge is - The United States' spend on healthcare is now $2.1 trillion. This is about two-thirds of the entire $3.2 trillion GDP of China – and growing nearly as fast!

**The Moral Imperative**

American's know that a solution is needed for the 47 million people who are uninsured. Any solution must include the sickest among us. No one can be left behind. Any system that works only for the young, healthy, and wealthy is a solution destined for failure.

According to the Institute of Medicine 18,000 people die every year because they are uninsured. Uninsured adults have a 25% greater rate of dying than adults with insurance. Uninsured trauma victims are 37% more likely to die of their injuries. Simply put, insuring all Americans is a moral imperative.

Addressing the uninsured is also an economic development opportunity. Uninsured sick children have impaired development and poor school performance. Uninsured adults have more absences from work, more unscheduled sick days, and greater rates of disability. Clearly, the cost to society is high.

Eight out of 10 uninsureds are in working families. The great job creation machine is small business. Yet, 65% with fewer than 10 employees do not offer health insurance. Too many are without health insurance for reasons beyond their control. Many more Americans are only a pink slip away from losing their jobs and their health insurance.

**A. Dysfunctional System**

The uninsureds are a symptom of a dysfunctional system. I believe that focusing on the uninsured rather than arguing over general market reforms will lead us to new solutions. Entrenched interests in broad reform protect their part of a dysfunctional system that operates within an outdated legal and regulatory environment with unintended consequences that makes little sense to average citizens.

For example, it is illegal under state laws for small group plans to provide financial rewards (dividends, rebates, refunds) to a diabetic following doctors orders to take medications, make scheduled office visits, or change diet and exercise habits. It is illegal under state laws to incent individuals with financial rewards healthy behaviors of wellness, prevention, and early intervention. States add a "sales tax" to every policy sold amounting to 2-3% or more of the premiums. In some areas of Georgia, state, local, county, city, and other municipal taxes can total as much as 7%. These are called "premium taxes" and add no value to providing care or

treatment. The added taxes only make insurance more unaffordable and increases the number of uninsureds. Amazingly, in 24 states it is illegal for small employers to contribute to the purchase of individual health policies through the use of tax advantaged Health Reimbursement Arrangements (HRAs).

It is generally illegal under federal law for an unemployed worker to use accumulated HSA savings to pay for health insurance premiums. It is illegal under federal law to provide a separate prescription drug benefit under High Deductible Health Plans. It is illegal under federal law for personally contributed but unused Flexible Savings Account funds to accumulate over time. These are multiple account designs with confusing rules and requirements that make no sense to average citizens. For the uninsured, a single universal health account would be much easier to understand.

While many wait for federal action to deal with the problem of the uninsureds, state legislation is taking place to support next generation health insurance.

**B. The Georgia Model**

As an example, let me share with you the recent successes in Georgia to cover 1/3 of our uninsureds. In our state and nationally, we have the best "Sickness-care" in the world. What we lack is a good "Health-care" system.

A collaboration of key stakeholders worked last year to develop recommendations to lower the uninsured in Georgia by about 500,000. The uninsured need insurance choices that should include affordable comprehensive coverage with a focus on wellness and prevention and meet all state requirements, patient protections, and privacy rights..

The WG determined that two segments of uninsured representing more than 1.1 million Georgians could benefit from their initial consensus recommendations. In Georgia (and nationally) about 30% of the uninsureds can afford insurance, but many find the products available unresponsive to their needs. Another 35% of the uninsured need some financial assistance. The WG believed that developing better more affordable products for these segments of uninsureds, with alternative methods of affordability, and improved wellness benefits could reach half of the initial targeted groups.

The collaborative effort succeeded. On May 7, 2008, Georgia's Governor Sonny Perdue signed into law health reform legislation that allows insurers to develop significantly more affordable products for small companies and individuals. The new laws focus on the uninsured working poor. With increased health, economic prosperity, security, and productivity this legislation is estimated to bring an annual increased economic value to Georgia of $1.9 billion.

**C. The Keys to Success**

The key to success was moving beyond the first generation HSA eligible plans to a new generation of consumer-oriented products. Critics have concerns regarding coverage under HSA eligible plans. The required up front deductibles have been a problem for many. With new generation plans these concerns are substantially moderated and potentially eliminated. Already federally tax advantaged, HSA eligible plans are typically 25-40% lower cost than traditional health insurance. 25-35% of new purchases of HSA eligible plans are sold to those otherwise previously uninsured. HSA eligible plans are required to be comprehensive (covering all disease states) and are mandated to limit maximum out-of-pocket costs. 84% of HSA eligible plans offer

100% coverage for preventive care. For example, full coverage is typically provided for mammograms, PSA tests, well child and healthy new mother programs.

The new Georgia law is a market-based individually-centered package of reforms that eliminate out-dated insurance laws that unintentionally limited the offering of affordable insurance. To make insurance more affordable, the new law allows financial "dividends" to be placed into Health Savings Accounts (HSAs) for engaging in wellness, prevention, and treatment compliance. Rewards and incentives paid into the HSA by insurers can reduce or eliminate the entire deductible otherwise payable by the patient. Affordability is no longer about the dollars one pays from a wallet. Affordability is also achieved through health choices and behavior changes.

In addition, Georgia eliminated all state and local "sales taxes" on HSA eligible plans (technically called premium taxes). As an incentive to offer insurance, companies (with fewer than 50 employees) are granted a $250 tax credit for each employee enrolled in an HSA eligible plan. For individual insurance buyers there is a special Georgia income tax deduction for the premium associated with the purchase of an HSA eligible plan. New more flexible plan designs are allowed that will offer choice, convenience, and cost savings.
The new Georgia law makes legally clear the option of small employers to contribute tax advantaged HRA dollars to employees for the purpose of buying individual portable health insurance and/or paying for health expenses.

Soon, Georgians will see products at a fraction of their current costs and be able to purchase portable new generation HSA eligible plans that can provide full coverage for those willing to take personal responsibility for their health and well-being. The old complaints that HSA eligible plans were simply high deductible coverage only for the young, healthy, and wealthy is addressed with the new products allowed under Georgia law.

A new future for improved health and family security is unfolding and Georgia is showing the way. Even though we are only one state, national and regional carriers are working to develop these new flexible affordable comprehensive plans. Millions of dollars in product development, training, education, promotion, advertising, commissions, and other economic activity is beginning to take shape. This legislation is not a panacea. It is a model for others to follow. Georgia is now prepared for the next phase of helping all Georgians to find affordable health insurance.

**D. National Megatrend of Transformation**

Georgia is reflective of a much broader change afoot. Led by large self-insured employers, there is a profound and fundamental transformation occurring across the nation. I believe we are 3-4 years into a 15 year mega-trend movement in healthcare. It is not surprising that many do not see what is happening as this evolution in health care is taking place. Many such changes are only fully recognized in historical perspective. Who knew when the Renaissance started, or when the Soviet Union began to fall?

The fundamental change happening is a movement from managed care which is based on the assumption that demand for healthcare is unlimited. Therefore, the only way to control costs is to limit the supply of care and/or cut provider reimbursements. Services are deemed not medically necessary, not appropriate, not covered, excluded, limited, and patients are told they are not sick enough, must wait for treatments, and choices are limited by formularies. This can be referred to as a "Supply Control" insurance system.

The transformation occurring is based upon controlling demand for services by engaging participants in healthy behaviors and providing rewards and incentives for cost effective use of healthcare services. This transformed world takes a different perspective on demand. Instead of assuming it is unlimited, new products are built on the ability to limit demand by changing behaviors. This can be referred to as a "Demand Control" insurance system.

We can solve the uninsured problem with these creative solutions, private/corporate efforts, tax incentives, direct public subsidies, strong community support, faith-based outreach programs, and effective enrollment in existing government programs. Personal responsibility, individual ownership, portability, and healthcare consumerism are the hallmarks of such a system.

The following list of federal reforms would support state actions of lowering the uninsureds and make health insurance affordable to more citizens:

1. Create a single universal HSA with flexible guidelines taking the best from HSAs, HRAs, and FSAs.
2. Remove federal income and employment taxes on individually purchased HSA eligible insurance premiums.
3. Allow the use of HSA funds for the payment of health insurance premiums.
4. Allow HSAs to be attached to any health insurance plan.
5. Allow HSA funding after Medicare eligibility to help the elderly fund copays, vision, and dental care.
6. Allow annual HSA contributions to be the maximum out-of-pocket expense under eligible plan limits.
7. Allow HSA eligible policies approved under the laws and regulations of any state to be sold in other states.
8. Allow prescription drug benefits with HSA eligible plans to be offered with co-pays.
9. Allow employers to voluntarily designate employer funded HSAs to be used only for healthcare while employed.
10. Provide tax incentives to accelerate the use of electronic medical records (EMRs) and other electronic (non-paper) systems through investment tax-credits or other similarly-situated tax incentives. Hospitals, physicians, and pharmacies could be incentivized to invest in health information technology.

The process has started. The need is great. The foundation blocks are bipartisan collaboration, support at the federal level, reform at the state level, creative product development, and citizen involvement in their own health and healthcare empowered financially with information and choices.

The mission is clear – Insure all Americans by 2012 in a 21st Century Intelligent Health System. The questions are: Who will help? Who will hinder? And who is willing to give power to consumers over their most precious asset – their health?

*Ronald E. Bachman FSA, MAAA is a Senior Fellow at the Center for Health Transformation, an organization founded by former U.S. House Speaker Newt Gingrich. Nothing written here is to be construed as necessarily reflecting the views of the Center for Health Transformation or as an attempt to aid or hinder the passage of any bill before any state legislature or the U.S. Congress.*

Mr. PALLONE. Thank you, Mr. Bachman, and I want to thank all the panel for being here today. Now we are going to questions and I will start with myself, and I wanted to ask my governor, one of my colleagues up here mentioned your being unique because you were a Senator for a number of years and now you are the governor of the State, and I know you talked about, we all know about your efforts to try to expand, to do health reform, to expand coverage on the State level. But you have often talked to me about how difficult that is or the challenges that exist if there isn't federal help. So my question really is, what are those challenges? I mean, how difficult will it be for New Jersey to expand coverage and maybe even ultimately get to have everyone covered without the help of the Federal Government and how can the Federal Government help?

Mr. CORZINE. Well, I think the panel discussion that you have heard here tells you one of the reasons why the Federal Government I believe needs to be involved. You need some kind of baseline standards with regard to a whole set of issues. I don't look forward to having preemption of the States of higher standards that might be set in any State but you need to be able to be assured that the quality of coverage from one place in Lambertville versus Bucks County is actually not going to end up having cost shifts onto emergency room care. Without some kind of baseline standards with regard to electronic medical record, we are not going to be able to build a national system that makes any sense. Preventative care and all of the other issues I think are going to need some common baseline activity.

Now, the initiatives of the Federal Government if you are a believer that they are good things, like Medicaid, Medicare, SCHIP, are going to require that there be a continuation of real federal financial support to be able to actually execute what is said. Otherwise what has happened in New Jersey in two different downturns already over an economic cycle, we end up rationing against what our capacity to be able to pay is and so you get an on-again, off-again implementation of SCHIP in its activities or a change in Medicaid copayments, which ends up rationing in a back-door way. We need some consistency in the financial flow from the Federal Government if we are going to be able to do it and particularly with respect to building the universal plans that we are trying to put together in the States. There is great flexibility shown by HHS with Massachusetts in shifting around how federal dollars that came to the State would be used and applied for purposes of it. Without that kind of flexibility for the different terms and conditions that we all face in different States—we have a high cost of living. I know there will be people that will complain that we go up to 350 percent of poverty but the cost of living in New Jersey is entirely different. Fifty thousand dollars of income for a family of four gets you way over spending a third of your dollars on housing in almost any situation, and it is incredibly important to maintain those flexibilities.

So, it is a longwinded answer saying we need baseline levels of requirements from the Federal Government. We need a real partner in finance and we need stability in how that is going to work. FMAP ought to be something that is an automatic stabilizer in my

view because you get every State backed into a corner that they end up having to cut healthcare expenditures at the very worst time.

Mr. PALLONE. Thank you, Governor. Yesterday we had a markup in the full committee and Mr. Deal talked about performance transparency, and I mentioned to him afterwards that there are various ways of dealing with hospital costs and particularly for the individual, and I mentioned that you recently signed into law a series of bills that reformed the way hospitals operate and one of those restricted the ability of hospitals to overcharge uninsured patients, which apparently was a common practice in New Jersey. Can you just talk about how uninsured patients were being disadvantaged and what steps, how that bill is trying to rectify that problem?

Mr. CORZINE. Well, Mr. Fox talked about this. This is cost shifting. If you aren't making enough money in one place and you have to survive, you end up placing it into the individual market, and what is even worse, you shift to the uninsured in a most exceptional way, hoping or expecting that you are going to get reimbursed on charity care or indigent funding, and it happens. People who manage the hospital systems understand this and it ends up being incentivized by how we are working. That is why we thought it would be very important reform that no one who is uninsured could be charged more than 115 percent of the Medicare charges for a particular function because you were seeing dramatically different charges for people who were insured often at that $100 that Mr. Fox talked about as he tried to describe the system. It needs to be done. There have to be all kinds of other transparency issues. You need Sarbanes-Oxley. I happen to be in favor of those kinds of things in how we actually manage the affairs of hospitals and we have a whole series of steps that we have taken there with regard to reform as well but I think that what we actually want to do is get everybody insured so that the shifting around to various uninsured segments or lesser insured segments doesn't end up being the person left without a chair at the party.

Mr. PALLONE. Thank you.

Mr. Deal.

Mr. DEAL. Thank you, and thank you, Governor Corzine, for leading the effort on transparency. I believe it is truly one of those missing elements in the discussions that we have. It is unfortunate when the uninsured or the individual who has a Health Savings Account or simply wishes to reach in their own pocket and pay for healthcare services is the person who pays the very highest price or at least is quoted the very highest price if in fact they can get a quote. We had the example yesterday, we talked about a young man who worked for a Congressman here who had to go in for an appendectomy. They thought he was uninsured and he got a bill for $19,000 for a one-night stay. When it was finally determined that he actually did have insurance, the insurance paid a little over $2,100. There is something wrong with that kind of system, and I applaud your efforts for leading efforts in transparency.

Mr. CORZINE. If I may, Mr. Deal, I would also say that is true on quality standards. We need transparency with regard to that.

Mr. DEAL. Here is the champion on that issue right here.

Mr. CORZINE. I think this is one of those areas though that I think there is a baseline, there is a lot of consensus on a number of areas where we have to move. Clearly how money flows in this system is obviously a debating point but there are a number of reforms that I think Congress can be extraordinarily helpful on if we moved in these areas on transparency and reporting.

Mr. DEAL. One of the big issues of course, and you mentioned it in terms of a bump in the FMAP that governors are asking for. My understanding is that the State of Rhode Island has now applied for a waiver from CMS that would give them greater flexibility as to how they administer their program with, I presume, the underlying assumption that if we could just get rid of some of these federal mandates in the Medicaid program, we could take the same amount of money and do more effective things like more preventive care, things that are tailored better to the needs of our constituents in our State. What is your reaction to that kind of an approach?

Mr. CORZINE. Well, most States would argue for flexibility and they ask for waivers for different purposes. We don't look at some of those requirements as so onerous. We look at them more as requirements so we might have a difference of view with how Rhode Island did it but we do believe that the States through the administration of this program and these cost-sharing elements that we have ought to have the flexibility to try to maximize. Now, whether Rhode Island is right and we are right on which ones, which elements of Medicaid ought to be attended to, you know, I will leave that to healthcare experts to tell me what is responsible. But flexibility is something that I think all of us are very much in favor of, "all of us" being governors, and I would support that concept. That is actually how the process with respect to Massachusetts mandate program has come into place, flexibility on how the money is used flowing to the State, and frankly, we have benefited in New Jersey because we have had under both Republican and Democratic administrations waivers that have allowed us to structure our program in the context of the needs of our community.

Mr. DEAL. One of the troubling things when we move from the public healthcare arena, whether it be Medicare or Medicaid, into talking about private insurance is the issue of mandates and mandates in coverage, and Dr. Parente, you have done extensive looks at that and your testimony alludes to it, some of your other documents even elaborate further. One of the illustrations, as I recall, and I have it here, is the difference between what somebody who is in Washington crossing New Jersey would pay as opposed to being across the Delaware River in Pennsylvania and I believe you indicated maybe it is twice as much in a private health insurance premium. Why is that and what can be done to deal with that?

Mr. PARENTE. Well, the result was actually driven by two things. One is the mandates themselves. Each mandate has an incremental cost to insurance in terms of underwriting. That is just a fact in terms of how these policies are sort of written out in terms of cost, and if you want to see it, any one of you can just go to ehealthinsurance.com, plug in the zip codes, put in your family profiles, that is why I did to sort of personify this or friends of families, and see what things look like. It is remarkable the premium differences for identical premium structures, identical meaning the

same coinsurance level, the same deductible, and even in some cases the same plan, United Health or Sigma, offering basically the same plan in either State but they have obviously State-specific offices but they are clearly trying to get some economies of scale. It is something that actually honestly surprised me how big the difference would be, and to see it actually on the one hand show up in theory but also backed up right by the price quotes you are seeing off e-health insurance is validated. Most of the research I do doesn't get validated that easily.

Mr. DEAL. Thank you. My time is expired. I yield back.

Mr. PALLONE. Let me just mention to the panel and to the members, we have a vote on the floor and about 12 minutes left. We have two votes. We are going to try to do one or two more members for questions and then we are going to have to break. I know that some of you can't stay. For those that can, we would ask you come back after the votes and continue.

Next is the gentlewoman from Illinois, Ms. Schakowsky.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman.

I wanted to ask you, Ms. Owen, or respond to some of the remarks that you made. I am looking at your employees now that you say is a win-win situation and they pay $1,956 a year in premiums, $163 a month, and then a $6,000 combined family deductible. So if someone in the family is sick and they have chosen the family plan, before any insurance kicks in, we are talking about $8,000, and I completely understand the challenges that small businesses have in providing their employees with healthcare and I think that is absolutely something that we need to address. But to call that a win-win situation, I can't understand how anybody could say having to pay $8,000 before you get any healthcare policy that that really works. Have you lost employees as a result if there is a health problem?

Ms. OWEN. No, actually as I said, my employees are the ones that listened to all the options that were available. We called in our insurance agent and we had a general meeting, and he presented all the different options that are available, and this is one they chose. We actually have had hardly any turnover where we used to have a lot of turnover so there is much more stability in my staffing. Obviously, the hope is that they would fund their savings portion of the HSA, maybe not this first year but as time goes on, and in the future as we grow that we could even help them fund that. But in general they are very happy with—I guess they are very pleased that they have insurance at all, because as I said, most——

Ms. SCHAKOWSKY. Let me just ask Ms. Edwards, the woman who whispered in your ear, would this kind of policy have met her needs?

Ms. EDWARDS. No. I mean, I think that if she had $6,000 to spend, she would have been able to get some sort of policy somewhat better than the policy that—$6,000 might have gotten her a policy. It certainly would have gotten her a screening at some level. But she didn't have that money to spend. I mean, the point is that we have a working mother doing everything basically right but she doesn't have the benefit of having even Ms. Owen as her employer so she has no health coverage whatsoever and so her options are

really closed. I want to say, there is a disincentive too for her to get checked because if she gets checked and finds out that in fact it is cancer, it makes her almost uninsurable. So there is a disincentive for her to find out even. So she doesn't have the money to spend to buy the insurance. She has a disincentive because of the way the system operates to get checked and it puts her on a very bad healthcare path.

Ms. SCHAKOWSKY. I am concerned—you wanted to say something?

Ms. OWEN. I just wanted to say, I think the benefit for my employees as they saw it was the fact that their wellness visits were covered whereas before they had the copay. They really never used their insurance and they liked the fact that their wellness visits are 100 percent covered, and once they meet their deductible, everything is 100 percent covered. So once they get to that point, sure there is a $6,000, $8,000 gap.

Ms. SCHAKOWSKY. Almost $8,000.

Ms. OWEN. But then they know that if there is a catastrophic illness, that they are covered, and I think that gives them a level of security.

Ms. SCHAKOWSKY. I am concerned often, and anyone can answer this, that we talk about, we divide the world between insured and uninsured too much and maybe this is for you, Dr. Davis, because as you pointed out, the problem of the millions of people who have inadequate health insurance, I think is too often overlooked. I wondered if you wanted to comment on some of the Commonwealth findings.

Ms. DAVIS. Well, absolutely, I think you are right to focus on the combination, the deductible, and the premium. Let us face it, the premium could be very low if it covered absolutely nothing so the real issue is what is the impact on the family. What the Commonwealth Fund survey showed in 2007, first of all, that we have had this major jump in people who are underinsured of 60 percent over 2003 but the underinsured have the same problems as the uninsured, both in terms of having access to care and in terms of medical bills or medical debt that they can't pay. Sixty-one percent of people who are underinsured report difficulties paying medical bills or they have accumulated medical debt. Sixty-one percent of the uninsured report bills or medical debts. Of those have insurance all year long and are adequately insured, 26 percent of those still have bills and medical debts. So you are exactly right that being underinsured is no advantage over being uninsured. You can still be wiped out financially. People are talking about having these debts on their credit cards. They are talking about having added to home equity line of credit as a result of these debts. So we need to look at the totality, the adequacy of the coverage, as Karen Pollitz has said, and the affordability of the premium together and not pat ourselves on the back that we have got the premium low but not covering anything. That is not the solution.

Mr. PALLONE. The gentlewoman's time is expired.

Ms. SCHAKOWSKY. Thank you.

Mr. PALLONE. As I said, we are going to recess now. I know that not everyone—well, there are only 5 minutes left. I know that not everyone can stay but we do want those of you who can to come

back. We have two votes, so that is about 15, 20 minutes. But the committee will stand in recess until the votes are completed.

[Recess.]

Mr. PALLONE. The subcommittee is back in session, and we left off with Mr. Murphy of Pennsylvania being next for questions. The gentleman is recognized.

Mr. MURPHY. Thank you, Mr. Chairman. I thank the panel for returning here. I heard a lot about universal healthcare but heard nobody talk about the cost. So I would like to have someone tell me how much universal healthcare would cost in this country. Yes?

Mr. PARENTE. It depends what you are talking about, but——

Mr. MURPHY. Just give me a number.

Mr. PARENTE. Roughly from here on out, probably $700 billion per year.

Mr. MURPHY. Does anybody else have a number on that?

Ms. EDWARDS. That is if you eliminate the employer-provided insurance. Is that correct?

Mr. PARENTE. No. That is just—if you really want to cover 45 million or 47 million people with reasonable medium-sized PPO coverage, slightly less than the Blues plan and FEHBP, that is about the price tag you are going to run.

Mr. MURPHY. Ms. Edwards, do you have a different number on that?

Ms. EDWARDS. I think we are talking about $120 billion.

Mr. MURPHY. Does anybody else have a number on that?

Ms. DAVIS. We have had Lewen do an estimate of something called building blocks. It is $82 billion a year without system reform, $31 billion federal budget costs a year with system reform.

Mr. MURPHY. And that means we still have the two-tiered system and the private insurance remains in place?

Ms. DAVIS. That particular proposal brings Medicaid up to Medicare rates and then starts equalizing private insurance and Medicare rates.

Mr. HOLLAND. Congressman, let me throw, if I may, a slight curve to you. We did some work at the Kansas Health Policy Authority, a couple of major foundations funded some work, and we did a series of alternative funding methodologies, and I asked them to look at what would it mean if we self-insured the entire State of Kansas.

Mr. MURPHY. OK.

Mr. HOLLAND. And we actually could cut the cost of healthcare in Kansas from $8.3 billion by about $800 million. I can provide you the detail. I would be happy to send it to you.

Mr. MURPHY. Well, now, when we look at the 47 million uninsured, one of the constant criticisms about that is those are people who also think they are uninsured but they are really on Medicaid, people who have options for insurance but they don't take it, people who are between jobs so they temporarily for 30 or 60 days do not have insurance. So that 47 million is not an accurate number, and I am trying to really figure this out. So when people talk about the cost of healthcare in this country as $2.1 trillion, how do we get to $700 billion, $120 billion, or $82 billion? I don't understand that. I mean, if we are going to say, OK, we are going to have people insured, and this is the thing about this and we talk about Medi-

care overhead is only 3 percent but we find that is a false number because doctors are always complaining they are not getting paid enough and so they have to find other ways to subsidize this so that number isn't—I don't know what the real number is. I look at the difference here, $700 billion, $120 billion, is a pretty big difference. I mean, I have trouble with CBO scoring things but this would be a nightmare. What is the cost of universal healthcare?

Mr. PARENTE. I could tell you one reason why the 700, why I sort of stand behind that number. That assumes basically that an average health plan that everyone has. It doesn't assume an SCHIP expansion. An SCHIP expansion is going to be far less. It is going to come closer to essentially coming up with that cost but keep in mind, SCHIP expansion for 47 million people, you will reduce costs and you will reduce costs but one of the concerns you are going to have is whether the providers will see them on 20-cents-on-the-dollar payment.

Mr. MURPHY. Well, so you can reduce costs by just saying we are not going to pay you?

Mr. PARENTE. Correct.

Mr. MURPHY. OK. I mean, I am concerned that one of the things I referred to earlier with the problems with safety and quality, there is about $400 billion of waste in the system. I know Governor Corzine alluded to some of those things and I think it is a massive savings we all ought to go after. I am just not comfortable that government could do it. For the last few years I have been fighting to have just hospitals report their infection rates. We can't get it past the lobbyists to say that hospitals ought to report how many people get infections and get killed. We can't get it past the Senate to say that doctors should be allowed to volunteer. I mean, we can't get through things that say we ought to be able to do disease management, which saves lots of money. We can't get it through Congress to show how we can be doing electronic medical records to save $162 billion directly, another $150 million in indirect. So my concern is, when we come up with these numbers, that assumes that everything works right, and this is where I struggle with this. But let me add a couple more points here. How do we pay for this?

Mr. PARENTE. The thing that I mentioned to you about covering just 10 million people would effectively be free. Now, there could be argument about whether or not——

Mr. MURPHY. How is it free?

Mr. PARENTE. You buy insurance across State lines.

Mr. MURPHY. But what about if the government ran universal healthcare? Who would pay for that?

Ms. EDWARDS. The way we have suggested is that by rolling back the tax cut for the people who make over $200,000, one proposal $250,000, another not to renew that tax cut would provide a revenue stream with which you could pay for it.

Mr. MURPHY. How much would that stream be? Do we know?

Ms. EDWARDS. Is it $180 billion? I would like to be able to modify that number when I find out exactly what it is.

Mr. MURPHY. Well, people in the top 5 percent of income earners pay about 60 percent of all taxes in American and the bottom 50 percent don't pay——

Ms. EDWARDS. That is an ideological argument with respect to it, but where the money comes from, that is where the money can come from. If I could make one other point, you had said earlier Medicare has 3 percent overhead.

Mr. MURPHY. No, that was what Dr. Davis said.

Ms. EDWARDS. But you said that is a false number because doctors aren't reimbursed. Well, the overhead would be the same if the doctors were reimbursed more.

Mr. MURPHY. It also doesn't include insurance companies subcontracting with Medicare and then the doctor's office has to do their own management of those things too so that is a lot of other overhead that is not included, but I do understand the issue too of insurance company overhead versus government overhead.

Ms. EDWARDS. But the doctors have to do that as well, don't they? The doctors also have to do that for insurance companies.

Mr. MURPHY. They get paid more. They get paid to have the staff to do that.

Ms. EDWARDS. But that doesn't affect the overhead number, which that is a separate number——

Mr. MURPHY. Sure, we say we are paying you less but you are going to have to eat the cost of overhead. I am just trying to figure out how this would work, and I know I am out of time here. Yes, Doctor?

Ms. DAVIS. I think we have to focus on two things, taking waste out of the system that benefits everybody and then the federal budget cost. Taking waste out of the system, we funded——

Mr. MURPHY. Waste being what?

Ms. DAVIS [continuing]. A study of doctors' administrative costs and the single biggest cost including the doctors' time are drug formularies that are different for every patient. So standardizing that would take that administrative burden off of doctors. System reform—

Mr. MURPHY. Standardizing formularies so that government chooses which drugs you get? That is what a formulary is. That is what the VA has. It says which drugs you can get and which ones you don't. I get a lot of calls in my office from people saying I can't get the drugs my doctor prescribed. So you are saying we will standardize this so the government——

Ms. DAVIS. Either standardize it or electronic prescribing mechanisms so the doctor knows when he writes the prescription, is this covered, rather than writing a prescription, the pharmacy calling them back——

Mr. MURPHY. The government decides what is covered and what is not and that is how we get savings. It comes down to this. We ration, we restrict or refuse care. That is what has happened in a lot of other governments and I hope—I mean, clearly, we have to wrestle with this. And please understand, I am trying to find some answers here but I want to make sure we—we are always asking the tough questions and I just hope this is the kind of hearings and discussions we continue to have because we have to get to the bottom of this and stop the political rhetoric but just say how does this work, what happens with taxes, what is the impact to the economy, who pays for it, what is all this, and we are a long way from there.

Mr. Chairman, thank you so much for indulging me a couple extra minutes. I appreciate the time.

Mr. PALLONE. Sure. The gentlewoman from California, Ms. Capps.

Ms. CAPPS. Thank you.

One aspect of the healthcare system that is costly, in line with the previous questions but also very frustrating to all Americans, is its mind-numbing complexity. Getting coverage, trying to figure out what a plans covers and navigating the paperwork confounds patients and providers alike. Ms. Edwards, you are a person who has had considerable dealings with the health system, yourself, and for your family members. Do you think this kind of mess would be improved or would be worsened by several of the different approaches toward coverage that have been discussed today?

Ms. EDWARDS. I think that if we had uniformity just in paperwork, we would see not only a great amount of savings in the system but we would also see a lot less frustration with the system. I know in my own treatment, you would receive a denial of coverage and you would have no idea, is this actually not covered under my policy or did somebody not check the right box at the doctor's office. There would be no way for you to discern from the document you received what exactly the problem was. Could you just submit some additional information and get it covered or was it never going to be covered? And this is my response, this is after I have been involved in talking about healthcare for a long time and spent 17 years as a lawyer, and I still couldn't make heads or tails of what I was receiving. An indication of how outrageous the system is and how irregular the responses are that you get, the lack of uniformity, I have an 8-year-old and a 10-year-old. They both had tonsillectomies this past year. We tried because we thought it would be a good idea to schedule them on the same day so they are going to go through the process together. This wasn't necessarily a good idea, I will tell you. But they were scheduled for the same day, the same doctor, the same anesthesiologist, the same operating room. Everything went smoothly. Later we started getting mail from the insurance company. Some things were covered for one child that were not covered for the other, exactly the same insurance company but that is the kind of irregularities you see when the system doesn't operate in a way that is clear to all the participants. I assume that the doctors all filled out the same forms but I don't know whether the person on the other end who was processing was the same person and we got a different result, and that is very frustrating and expensive. It means that I am going to communicate with the insurance company, which is going to cost them money to try to figure it out, and we are burdening the system unnecessarily. There are easy ways for us to fix some of these problems. Uniform electronic transmission of records is obviously one. Single kinds of forms that we use that are written in plain English would be another way in which we could alleviate some of the burden of the system both economically and emotionally for the participants.

Ms. CAPPS. Thank you very much.

I want to turn to you, Karen Pollitz, with a California kind of orientation, if you don't mind. I represent a district there. You tes-

tified that health insurance must be available, affordable, and adequate all of the time but that in the individual health insurance market some insurers have been pulling the plug on their policyholders, leaving them uninsured and uninsurable. Specifically, you mentioned the practice of rescinding policies—that is the part that we have had some high-profile cases on in California—retroactively canceling policies after expensive claims start to come in, refusing to pay the claims and returning the premiums. Unfortunately, this is not just fly-by-night companies either that engage in this practice in California. The State Department of Managed Healthcare recently fined five large nationally known insurers a total of $14 million for unlawful rescissions and cancellations. Why do you believe it is the case that these insurers rescind or cancel so many policies when there was no fraud against them by the policyholder? Is this just the way business is done today and what should we be doing about it?

Ms. POLLITZ. This is actually not just a California problem, it happens everywhere, and it is not a new problem. It is recently reported on by the L.A. Times but it has been going on for a long time, and practices do vary across insurance companies. A lot of it has to do with having an underwritten market in the first place but this is competition based on risk selection. This is what happens when the market competes to the bottom without any rules, and insurers are different. Some I think are more meticulous and careful with their underwriting to try to screen people out at the beginning and not issue them coverage but there are companies that have kind of adopted the philosophy that I don't need to spend as much time and energy underwriting at the front end because I will catch it on the back end if I need to. The rules vary that govern this. It is not only rescissions that can be the result. Post-claims investigations can also result in a preexisting condition exclusion or a rider being imposed retroactively on a policy, a premium surcharge imposed retroactive, and it is not just an individual market problem. Post-claims investigations also occur in small group coverage. So unless there are very strict and standard rules of the road that govern these practices, they will continue.

Ms. CAPPS. I know my time is up, but yesterday our ranking member had a very poignant story when we were discussing breast cancer on this very topic, and just a quick question with a quick answer if you don't mind. Is there a role then we should be playing here in setting these guidelines or in making some kind of standard here?

Ms. POLLITZ. Absolutely. I mean, the easiest rule is to just say there isn't any underwriting, people get coverage and once they have got it, it sticks, and short of that in an underwritten market, you can have much more standardized rules about how questions are asked so there aren't these kind of gotcha questions where you can make a mistake. I mean, you already have a federal standard that says except in the case of fraud you can't cancel a policy. I think in many States the insurance industry is operating below that standard and you can enforce what you have in current law.

Ms. CAPPS. Thank you very much.

Mr. PALLONE. Thank you. This concludes our questions, but as Mr. Murphy suggested, we could obviously go on all day and sev-

eral days and several weeks, and I appreciate the fact that you are willing to come here today, and we did have, I think, a very good discussion about the need for healthcare reform. My intention is that beginning next year, because this is probably the last hearing the subcommittee will have before we adjourn next week, that we will start the year and have many more opportunities like this to talk about what needs to be done. I mean, obviously there is going to be a change in the White House regardless of who is elected, and we want to sort of get the ball rolling, if you will, on different options, because the problems with cost, the problems with the uninsured, the problems with access I think are only getting worse and I do appreciate the fact that all of you spent the time today and were able to answer our questions very effectively.

Let me mention that we may get members that send you some written questions to follow up, and those are submitted to the committee clerk within the next 10 days, so you may get some questions to answer in writing within the next 10 days or so, and we will certainly appreciate your response.

Thank you again, and without objection, this meeting of the subcommittee is adjourned.

[Whereupon, at 1:00 p.m., the subcommittee was adjourned.]